Plan Document and Summary Plan Description for the Kenmore Town of Tonawanda Union-Free School District Passport Select Plan

- Medical and Prescription Drug Benefits
- Vision Benefits

Effective Date: 07/01/2015

Introduction

Kenmore Town of Tonawanda Union Free School District (the "Employer" or "Company") is pleased to offer you this benefit plan. It is a valuable and important part of your overall compensation package.

This booklet describes your medical and prescription drug benefits, vision benefits and serves as the Summary Plan Description (SPD) and Plan document for the Kenmore Town of Tonawanda Union-Free School District Passport Select Plan ("the Plan").

This document sets forth the provisions of the Plan that provide for payment or reimbursement of Plan benefits.

We encourage you to read this booklet and become familiar with your benefits. You may also wish to share this information with your enrolled family members.

This Plan and SPD replace all previous booklets you may have in your files. Be sure to keep this booklet in a safe and convenient place for future reference.

Table of Contents

Plan Overview

Your Eligibility

You are eligible for benefits if you are:

- A full-time active employee;
- A part-time active employee;
- Covered as an employee under the terms of a collective bargaining agreement between the Company and the applicable collective bargaining agreement;
- A retired employee;
- On the regular payroll of the Company; and
- In a class of employees eligible for coverage.

Unless otherwise communicated to you in writing by the Company, the following individuals are not eligible for benefits: employees of a temporary or staffing firm, payroll agency or leasing organization, persons hired on a seasonal or temporary basis, independent contractors and other individuals who are not on the Company payroll, as determined by the Company, without regard to any court or agency decision determining common-law employment status.

Eligible Dependents

You may enroll your eligible dependents on your coverage. Your eligible dependents include:

- your legal spouse;
- your child under age 26 regardless of financial dependency, residency with you, marital status, or student status;
- your unmarried child of any age who is principally supported by you and who is not capable of self-support due to a physical or mental disability that began while the child was covered by the Plan; or
- your unmarried child of any age who is not capable of self-support due to a physical or mental disability that occurred before age 26, whose disability is continuous, and who is principally supported by you.

“Principally supported by you” means that the child is dependent on you for more than one-half of his or her support, as defined by Code Section 152 of the Internal Revenue Code.

For purposes of the Plan, your child includes:

- your biological child;
- your legally adopted child (including any child lawfully placed for adoption with you);
- your stepchild;
- a foster child who has been placed with you by an authorized placement agency or by judgment decree or other court order;
- a child for whom you are the court-appointed legal guardian;

- an eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

An eligible dependent does not include a person enrolled as an employee under the Plan or any person who is covered as a dependent of another employee covered under the Plan. If you and your spouse are both employed by the Company, each of you may elect your own coverage (based on your own eligibility for benefits) or one of you may be enrolled as a dependent on the other's coverage, but only one of you may cover your dependent children.

It is your responsibility to notify the Company if your dependent becomes ineligible for coverage.

Proof of Dependent Eligibility

The Employer reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan. If you are asked to verify a dependent's eligibility for coverage, you will receive a notice describing the documents that you need to submit. To ensure that coverage for an eligible dependent continues without interruption, you must submit the required proof within the designated time period. If you fail to do so, coverage for your dependent may be canceled.

When Coverage Begins

For You

Your health care coverage begins on the first day of your employment and after you meet all eligibility requirements.

If you terminate employment and are subsequently rehired, you will need to satisfy any eligibility requirements to be covered under the Plan.

For Your Dependents

Coverage for your eligible dependents begins on the same day as your initial eligibility provided you timely enroll your dependents in coverage.

If you acquire a new dependent through marriage, birth, adoption or placement for adoption, you can add your new dependent to your coverage as long as you enroll the dependent within 31 days of the date on which they became eligible. If you wait longer than 31 days, you may be required to wait until the Plan's next open enrollment period to enroll your new dependent for coverage.

A newborn child will be automatically covered by the Plan while the birth mother is hospital-confined. Coverage will continue only if you enroll him or her on your coverage within 31 days of birth. If you wait longer than 31 days after the date of birth, you may not be able to enroll your newborn child until the next annual open enrollment period.

Charges for nursery or physician care will be initially applied toward the plan of the covered parent. If the newborn child is not enrolled in the Plan on a timely basis, the covered parent will be responsible for all costs.

Your Cost for Coverage

Both the Company and you share in the cost of your health care benefits. Each year, the Company will evaluate all costs and may adjust the cost of coverage during the next annual enrollment. Your enrollment materials will show the coverage categories available to you.

You pay your portion of this cost through after-tax or pre-tax payroll deductions taken from your pay each pay period. Your actual cost is determined by the coverage you select and the number of dependents you cover. You must elect coverage for yourself in order to cover your eligible dependents.

Enrolling for Coverage

New Hire Enrollment

As a newly eligible employee, you will receive enrollment information when you first become eligible for benefits. To enroll in medical and/or prescription drug and/or vision coverage, you will need to make your coverage elections by the deadline shown in your enrollment materials. When you enroll in the Plan, you authorize the Company to deduct any required premiums from your pay.

The elections you make will remain in effect until the next June 30, unless you have a qualifying change in status. After your initial enrollment, you will enroll during the designated annual open enrollment period. If you do not enroll for coverage when initially eligible, you will only be eligible for the default coverages designated by the Plan Administrator, as shown in your enrollment materials.

You will automatically receive identification (ID) cards for you and your eligible dependents when your enrollment is processed.

Late Entrant

Your enrollment will be considered timely if your completed enrollment form is received within 31 days after you become eligible for coverage. You will be considered a “late entrant” if:

- You elect coverage more than 31 days after you first become eligible
- You again elect coverage after canceling

Unless the Special Enrollment Rights (see below) apply, if you are a late entrant, you will be required to wait until the next open enrollment period (but no longer than 12 months) to enroll in coverage.

Annual Open Enrollment

Each year during a designated open enrollment period, you will be given an opportunity to make your elections for the upcoming year. Your open enrollment materials will provide the options available to you and your share of the premium cost, as well as any default coverage you will be deemed to have elected if you do not make an election by the specified deadline. The elections you make will take effect on the following July 1 and stay in effect through June 30, unless you have a qualifying change in status.

Effect of Section 125 Tax Regulations on this Plan

It is intended that this Plan meets the requirements of the Internal Revenue Code Section 125 and the regulations thereunder and that the qualified benefits which you may elect are eligible for exclusion from income. The Plan is designed and administered in accordance with those regulations. This allows you to elect to pay your share of the cost for coverage on a pre-tax basis. Neither the Company nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by you by virtue of your participation in the Plan.

Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections. Generally, your elections stay in effect for the Plan Year and you can make changes only during each annual open enrollment. However, at any time throughout the year, you can make changes to your coverage within 31 days following:

- The date you have a qualifying change in status as described below;
- The date you meet the Special Enrollment Rights criteria described below.

Qualifying Change in Status

If you experience a change in certain family or employment circumstances that results in you or a covered dependent gaining or losing eligibility under a health plan, you can change your coverage to fit your new situation without waiting for the next annual open enrollment period.

As defined by the Internal Revenue Service (IRS), status changes applicable to health care coverage include:

- your marriage;
- the birth, adoption, or placement for adoption of a child;
- your death or the death of your spouse or other eligible dependent;
- your divorce, annulment, or legal separation;
- a change in a dependent child’s eligibility due to age or eligibility for other coverage;
- a change in employment status for you or your spouse that affects benefits (including termination or commencement of employment, strike or lockout, or commencement of or return from an unpaid leave of absence);
- employee's spouse's open enrollment period differs and employee needs to make changes to account for other coverage;
- a reduction or loss of your or a dependent’s coverage under this or another plan;
- a court order, such as a QMCSO or NMSN, that mandates coverage for an eligible dependent child;

If you experience a change in certain family or employment circumstances, you can change your coverage. Changes must be consistent with status changes as described above. For example, if you get married, you may change your coverage level from you only to you and your spouse. If you move, and your current coverage is no longer available in the new area, you may change your coverage option.

You should report a status change as soon as possible, but no later than 31 days, after the event occurs.

Keep in mind that certain mid-year election change events do not apply to health Flexible Spending Accounts (FSAs), such as cost or coverage changes. Contact the Plan Administrator if you have questions about when you can change your elections.

Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because you have other health coverage, you may be able to enroll yourself and your dependents in this Plan, if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

You or an affected eligible dependent may also enroll in coverage if eligibility for coverage is lost under Medicaid or the Children's Health Insurance Program (CHIP), or if you become eligible for premium assistance under Medicaid or CHIP. You must enroll under this Plan within 60 days of the date you lose coverage or become eligible for premium assistance.

This "special enrollment right" exists even if you previously declined coverage under the Plan. You will need to provide documentation of the change. Contact the Plan Administrator to determine what information you will need to provide.

When Coverage Ends

Your coverage under this Plan ends on the last day of the month in which your employment terminates or you cease to be an eligible employee unless benefits are extended as described below.

Coverage for your covered dependents ends when your coverage ends or, if earlier, on the last day of the month in which your dependent is no longer eligible for coverage under the Plan.

Coverage will also end for you and your covered dependents as of the date the Company terminates this Plan or, if earlier, the effective date you request termination of coverage for you and your covered dependents.

If your coverage under the Plan ends for reasons other than the Company's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) as described below.

Cancellation of Coverage

If you fail to pay any required premium for coverage under the Plan, coverage for you and your covered dependents will be canceled and no claims incurred after the effective date of cancellation will be paid.

Rescission of Coverage

Coverage under the Plan may be rescinded (canceled retroactively) if you or a covered dependent performs an act, practice or omission that constitutes fraud, or you make an intentional misrepresentation of material fact as prohibited by the terms of the Plan. A rescission of coverage is an adverse benefit determination that you may dispute under the

Plan's claims and appeals procedures. If your coverage is being rescinded due to fraud or intentional misrepresentation of material fact, you will receive at least 30 days' advance written notice of the rescission. This notice will outline your appeal rights under the Plan. Benefits under the Plan that qualify as "excepted benefits" under HIPAA are not subject to these restrictions on when coverage may be rescinded. Some types of retroactive terminations of coverage are permissible even when fraud or intentional misrepresentation are not involved. Coverage may be retroactively terminated for failure to timely pay required premiums or contributions as required by the Plan.

Also, coverage may be retroactively terminated to the date of your divorce if you fail to notify the Plan of your divorce and you continue to cover your ex-spouse under the Plan. Coverage will be canceled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by you or your covered dependent.

The Plan reserves the right to recover from you and/or your covered dependents any benefits paid as a result of the wrongful activity that are in excess of the contributions paid. In the event the Plan terminates or rescinds coverage for gross misconduct on your behalf, continuation coverage under COBRA may be denied to you and your covered dependents.

Coverage While Not at Work

In certain situations, health care coverage may continue for you and your dependents when you are not at work, so long as you continue to pay your share of the cost. If you continue to be paid while you are absent from work, any premium payments will continue to be deducted from your pay on a pre-tax basis. If you are not receiving your pay during an absence, you will need to make arrangements for payment of any required premiums. You should discuss with your supervisor what options are available for paying your share of costs while you are absent from work.

If You Are Temporarily Laid Off

If you are laid off for a temporary period of time, your health care coverage will continue through the end of the month in which your layoff begins.

If You Take a Leave of Absence – FMLA

If you take an approved FMLA leave, your coverage will continue for the duration of your FMLA leave, as long as you continue to pay your share of the cost as required under the Company's FMLA Policy.

If You Take a Military Leave of Absence

If you are absent from work due to an approved military leave, health care coverage may continue for up to 24 months under both the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and COBRA, which run concurrently, starting on the date your military service begins.

If You Are Permanently Laid Off

If you are permanently laid off (separated from service), your health care coverage will continue through the end of the month in which your layoff begins.

Your Medical Benefits

Your medical benefits are delivered through a network of participating doctors, hospitals, laboratories, home health care agencies, and other health care providers, who have agreed to provide services at a discounted cost.

The Plan does not require you to select a primary care physician to coordinate your care and you do not have to obtain a referral to see a specialist.

A network of providers gives you the flexibility to choose providers inside or outside the network each time you need care. In most cases, the Plan covers the same medical services whether you receive care in- or out-of-network. Refer to the benefit summary booklet issued by your Claims Administrator, Ken-Ton Passport Select Schedule of Benefits, for a more detailed summary of your health care benefits and how benefit are paid in- and out-of-network. The benefit summary booklet is incorporated by reference as part of this SPD.

To obtain a listing of current providers (at no cost to you) or confirm whether a provider participates in the network, contact the claims administrator for the network shown on your ID card.

If you use in-network providers, the Plan pays a higher percentage of covered expenses (after you meet any applicable deductible). Generally, you will not be required to file a claim form when you receive in-network benefits but in some cases, the provider or claims administrator may require you to do so.

If you receive professional services for anesthesiology, radiology, emergency room physician services, or pathology which are provided by an out-of-network provider but rendered at in-network facility, those services will be paid at the in-network level of benefits.

If you use out-of-network providers, the Plan pays a lower percentage of covered expenses (after you meet any applicable deductible), up to the reasonable and customary limit or maximum plan allowance (see explanation below). You are responsible for charges in excess of this limit and this excess amount may not apply to your deductible or any out-of-pocket maximum. You may also pay a higher deductible and out-of-pocket maximum (if applicable) out-of-network, and you may be required to file claim forms. Refer to your benefit summary booklet for additional information.

However, if you travel into an area that offers an in-network provider, and you choose not to use the in-network provider, then all services will be covered at the out-of-network level of benefits as described above.

Your Deductible

A deductible is money you must pay for certain covered expenses before the Plan pays benefits. It is calculated on a plan year basis.

Your Co-payment

Some services may require a co-payment – a fixed dollar amount you must pay before the Plan pays for that service. Copayments may apply regardless of whether the deductible has been satisfied. Please refer to the Summary of Medical Benefits chart for any required copayments and if the deductible may need satisfied before copayments are applied.

Your Coinsurance

Once you meet your deductible, the Plan pays a portion, or percentage, of certain covered medical expenses, and you are responsible to pay a portion. The percentage you must pay is called your coinsurance. For most services, the Plan will pay a higher percentage of the cost when you receive care in-network, which means your percentage will be lower.

The amount or percentage you pay depends on the type of provider you see, where you receive services, and how you are billed for these services. Your benefit summary booklet provided by the Claims Administrator will show the co-payment and coinsurance amounts for common medical services both in-network and out-of-network.

Out-of-Pocket Maximum

The out-of-pocket maximum limits the total portion of costs you must pay in annual medical deductibles, coinsurance and copayments. It is calculated on a plan year basis. When your share of eligible out-of-pocket medical expenses reaches the out-of-pocket maximum, your coinsurance percentage and copayments become zero for the rest of the year – and the Plan pays 100% of covered expenses. Your benefit summary booklet will show any applicable out-of-pocket maximum amounts.

Maximum Allowed Amount (Reasonable/Usual and Customary Limits)

If you use out-of-network providers, covered medical expenses are subject to certain limits under the Plan, and you are responsible for paying any charges above this limit. The maximum benefit payable is based on the amount determined by the Plan to be the prevailing charge for a covered service or supply. Determination of the prevailing charge is based on the:

- complexity of the service and level of specialty of the provider;
- range of services provided; and
- the geographic area where the provider is located and other geographic areas with similar medical cost experience.

Eligible Expenses

Eligible expenses are for services and supplies that are approved by a physician or other approved provider and must be medically necessary for the care and treatment of a covered sickness, accidental injury, pregnancy or other covered health care condition. Services received from an out-of-network provider are subject to the Reasonable and Customary limit (see above). Refer to your benefit summary booklet for additional information.

For More Information

If you have a question about a covered service, or for more information about a specific procedure or service described above, contact the claims administrator at the number listed on the back of your ID card.

Expenses Not Covered

Ineligible expenses and expenses not covered by the plan are shown in the benefit summary booklet provided by your Claims Administrator.

Precertification

You and your covered dependents are required to obtain precertification for inpatient hospitalization as shown in your benefit summary booklet. In some cases, the in-network provider may obtain the precertification for you; however, to ensure that you receive the maximum benefit, you should verify that the request was submitted to the Plan.

To receive the maximum benefit and avoid any penalty for failure to precertify, you must call the number listed on the back of your ID card to precertify an admission or treatment:

- at least 2 weeks prior to any scheduled or non-emergency hospital admission or treatment;
- within 48 hours of an emergency or unscheduled admission. Your case will be reviewed by the Plan to determine how many days of treatment are medically necessary.

Precertification - Pregnancy and Childbirth

Precertification will not be required for an inpatient admission for pregnancy delivery that does not exceed 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.

Penalty for Noncompliance with Precertification

If precertification requirements are not met, any covered expenses incurred will be reduced by 50%, up to a maximum of $500. In addition, if it is determined subsequently that all or part of the hospital stay was not medically necessary, all or part of the hospital confinement expenses will be denied and benefits will not be paid beyond the number of days considered medically necessary.

The precertification coordinator will work with your physician to determine the appropriate length of stay for your condition. If an extension is required for your hospital confinement, you (or a family member or your attending physician) must obtain approval for the extension before the original approved stay expires. If an extension is approved, you, your attending physician, and the hospital will receive written notification of the approval. If the criteria for an extended stay are not met, your stay will be denied and you may file an appeal of the denial through the Plan’s appeal process.

Case Management

Through the case management program, you receive appropriate health care services for serious or catastrophic medical conditions. The Plan Administrator may arrange for review and/or case management from a professional who is qualified to perform such services. The Plan Administrator has the right to alter or waive the normal provisions of the Plan when it is reasonable to expect a cost-effective result without sacrificing the quality of patient care. The case management program may provide benefits or alternative care not otherwise routinely available through the Plan under special circumstances.

While many diagnoses may require special attention, the Plan may use case management for conditions such as, but not limited to:

- Acquired Immune Deficiency Syndrome (AIDS);
- burns;

- coma;
- inpatient confinement expected to exceed 14 days;
- multiple sclerosis/Amyotrophic Lateral Sclerosis (Lou Gehrig's disease);
- neonatal birth;
- organ transplant;
- progressive neurological debilitative disease;
- certain psychiatric conditions;
- quadriplegic/paraplegic conditions;
- stroke; and
- multiple traumas from a vehicular accident.

Benefits provided under the program are subject to all other Plan provisions. Alternative treatments will be determined on the merits of each individual case and will not be considered as setting any precedent or creating any future liability with respect to any participant. Case management will be involved for in-network and out-of-network services that meet the established criteria.

Your Prescription Drug Benefits

How the Plan Works

If you elect medical coverage under the Plan, you are automatically enrolled in the Prescription Drug program. Your Plan helps pay the cost of covered prescription drugs that are medically necessary for treatment of a sickness or injury. Covered drugs must be:

- prescribed by a licensed physician or dentist and dispensed by a registered pharmacist; and
- approved by the United States Food and Drug Administration (FDA) for general use in treating the illness or injury for which they are prescribed.

Additional information about covered drugs and supplies can be found in the benefit summary booklet provided by the Claims Administrator.

Managed Pharmacy Network

Prescription drug benefits are provided through a managed pharmacy network.

You may purchase covered prescription drugs at any participating network retail pharmacy.

The coverage categories, any deductible, your coinsurance or co-payments, maximum payments, and other cost-sharing provisions are explained in the benefit summary booklet issued by the Claims Administrator which is incorporated by reference as a part of this SPD.

Using a Network Retail Pharmacy

The retail pharmacy network includes most chain and many local pharmacies. You will receive a prescription drug identification (ID) card from the Claims Administrator. Present this card to the network pharmacy when you purchase covered prescription drugs. There are no claim forms to complete.

If You Use an Out-of-Network Retail Pharmacy

Coverage for prescriptions purchased at out of network pharmacies are not covered under this plan.

Mail-Service Program

The mail-service program is a cost-effective and convenient way to purchase up to a 90-day supply of covered medication through the mail. The mail-service program is used for maintenance prescription drugs, such as blood pressure medication, taken on a regular or long-term basis. It also can be used for any medication that is not needed immediately. Non-formulary drugs are not eligible to be filled through the mail service program.

To fill a prescription through the mail-service program, you must complete an order form and include your co-payment (using a credit card, check, or money order). With your first order, you also must include the original prescription order written by your doctor and a completed patient profile form.

Your filled prescription will be mailed directly to your home. Your order will include a preprinted envelope and a notice with instructions on how to request a refill prescription; you

will not need a new prescription from your doctor if the prescription is still valid. Prior Authorization and Limits

Certain prescriptions may require prior authorization by the Claims Administrator. This process allows the Plan to verify that the drug is a part of a specific treatment plan and is medically necessary. Your physician will need to contact the Claims Administrator with written documentation of the reason for prescribing the medication and the length of time it should be covered. If you discover that a prescription requires prior authorization while you are at a retail pharmacy, you or the pharmacist will need to contact your doctor, who must then contact the Claims Administrator.

If your prescription is authorized by the Plan, you will be able to fill your prescription at any participating pharmacy or through the mail service program. If authorization is not received, you will be required to pay the full cost of the prescription.

Certain drugs may also be limited by drug-specific quantity limitations per month, benefit period, or lifetime as specified by the Plan and based on medical necessity. Other drugs may be covered under your medical benefits and will be subject to your deductible and coinsurance.

Expenses Not Covered

Ineligible medications and expenses not covered by the plan are shown in the benefit summary booklet provided by your Claims Administrator.

For More Information

If you have a question about a covered prescription or supply, or for more information about a specific drug or service described above, contact the Claims Administrator at the number listed on the back of your ID card.

Your Vision Benefits

If you elect medical coverage under the Plan, you are automatically enrolled in the Vision program. Your vision benefits are delivered through a network of participating ophthalmologists, optometrists, and other providers who have agreed to provide services at a discounted cost.

Network Providers

You should refer to the benefit summary booklet issued by the Claims Administrator, Ken-Ton Passport Select Schedule of Benefits, for a more detailed summary of what vision benefits are covered under the Plan and how benefits are paid when you use participating providers. The benefit summary booklet and other materials provided by the Claims Administrator are incorporated by reference as part of this SPD. Those materials contain any deductible, copayments or coinsurance that apply to covered benefits, limitations, maximum benefits payable, exclusions, or any other discounts that may apply.

To locate a provider or to find out if your provider participates in the network, contact Eyemed Vision Care at 1-877-842-3348 or visit their website at Eyemedvisioncare.com. Benefits are available through participating providers only.

Eligible Expenses

Eligible expenses are those provided for services and supplies that are authorized by and approved by your physician or other approved provider. Expenses must be medically necessary for the care and treatment of a covered procedure or condition. Refer to the benefits booklets provided by the Claims Administrator for detailed information regarding benefits covered and excluded under the Plan.

For More Information

If you have questions about a covered or excluded benefit or service, or for more information about a specific procedure, refer to your benefit booklets or contact the Claims Administrator at the number listed on the back of your ID card.

Administrative Information

The following sections contain legal and administrative information you may need to contact the right person for information or help. Although you may not use this information often, it can be helpful if you want to know:

- how to contact the Plan Administrator;
- how to contact the Claims Administrators;
- what to do if a benefit claim is denied; and
- your rights under Federal laws such as COBRA.

Plan Sponsor and Administrator

Kenmore Town of Tonawanda Union Free School District is the Plan Sponsor and the Plan Administrator for this Plan. You may contact the Plan Administrator at the following address and telephone number:

Kenmore Town of Tonawanda Union Free School District
1500 Colvin Boulevard
Buffalo, NY 14223
716-874-8400

The Plan Administrator will have control of the day-to-day administration of this Plan and will serve without additional remuneration if such individual is an employee of the Company. The Plan Administrator will have the following duties and authority with respect to the Plan:

- To prepare and file with governmental agencies all reports, returns, and all documents and information required under applicable law;
- To prepare and furnish appropriate information to eligible employees and Plan participants;
- To prescribe uniform procedures to be followed by eligible employees and participants in making elections, filing claims, and other administrative functions in order to properly administer the Plan;
- To receive such information or representations from the Company, eligible employees, and participants necessary for the proper administration of the Plan and to rely on such information or representations unless the Plan Administrator has actual knowledge that the information or representations are false;
- To properly administer the Plan in accordance with all applicable laws governing fiduciary standards;
- To maintain and preserve appropriate Plan records.

In addition, the Plan Administrator has the discretionary authority to determine eligibility under all provisions of the Plan; correct defects, supply omissions, and reconcile inconsistencies in the Plan; ensure that all benefits are paid according to the Plan; interpret Plan provisions for all participants and beneficiaries; and decide issues of credibility necessary to carry out and operate the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

Plan Year

The Plan Year is July 1 through June 30.

Type of Plan

This Plan is called a “welfare plan”, which includes group health plans; they help protect you against financial loss in case of sickness or injury.

Identification Numbers

The Employer Identification Number (EIN) and Plan number for the Plan is:

EIN: 16-6002097 PLAN NUMBER: 501

Plan Funding and Type of Administration

Funding and administration of the Plan is as follows.

Type of Administration	Benefits are self-funded and are administered through contracts with third-party administrators.
Funding	The Company and employees both contribute to the Plan. The Company will use these contributions to pay benefits to or on behalf of Plan Participants from the Company’s general assets. Employee contributions toward the cost of a particular benefit will be used in their entirety prior to using Company contributions to pay for the cost of such benefit.

Claims Administrators

The Plan Administrator has contracted with the following company(ies) to administer benefits and pay claims. You may contact the appropriate Claims Administrator directly, using the information listed below. Your Claims Administrator is listed on your ID card.

The Plan Administrator has also contracted with different third-party administrators, to handle certain day-to-day administrative functions such as utilization review, provider contracting and prescription benefit management for the Plan. While these service providers make every attempt to provide accurate information, mistakes can occur. It is important to understand that the Plan documents always control, even if their terms conflict with information given to you by a service provider.

Medical /Utilization Review

Claims Administrator

Independent Health
P.O. Box 9066
Buffalo, NY 14231
716-631-2661
www.independenthealth.com

Prescription Drug Administrator

Pharmacy Benefit Dimensions
511 Farber Lakes Drive
Buffalo, NY 14221
716-631-2661
www.pbdrx.com

COBRA Administrator

Nova Healthcare Administrators, Inc.
6400 Main Street
Suite 210
Buffalo, NY 14221
716-932-5000
www.novahealthcare.com

Vision Administrator

EyeMed Vision Care
4000 Luxottica Place
Mason, OH 45040
877-842-3348
www.eyemedvisioncare.com

Agent for Service of Legal Process

If any disputes arise under the Plan, papers may be served upon:

Kenmore Town of Tonawanda Union Free School District
1500 Colvin Boulevard
Buffalo, NY 14223
716-874-8400

Service of legal process also can be made upon the Plan Administrator.

No Obligation to Continue Employment

The Plan does not create an obligation for the Company to continue your employment or interfere with the Company's right to terminate your employment, with or without cause.

Severability

If any provision of this Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions shall continue to be fully effective.

Payment of Benefits

All benefits are payable when the Plan Administrator receives written proof of loss. Benefits will be payable to the covered participant, unless otherwise assigned. If you receive care from a non-network provider, it is your responsibility to pay the non-network provider for the charges you incurred, including any difference between what you were billed and what the Plan paid. You may not assign your benefits under the Plan to a non-network provider without

the Company's consent. The Company (or a Claims Administrator) reserves the right, in its discretion, to pay a non-network provider directly for services rendered to you. Direct payment to a non-network provider shall not be deemed to constitute consent by the Company or waive the consent requirement for assigning benefits.

Payment of Benefits to Others

The Plan Administrator, in its discretion, may authorize any payments due to be paid to the parent or legal guardian of any individual who is either a minor or legally incompetent and unable to handle his or her own affairs.

Expenses

All expenses incurred in connection with the administration of the Plan, are Plan expenses and will be paid from the general assets of the Company.

Fraud

No payments under the Plan will be made if the participant or the provider of services attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Plan Administrator will have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made. The Plan will have the right to recover any amounts, with interest, improperly paid by the Plan by reason of fraud. Any employee or his or her covered dependent who attempts or commits fraud upon the Plan may have their coverage terminated and may be subject to disciplinary action by the Company, up to and including termination of employment.

Indemnity

To the full extent permitted by law, the Company will indemnify the Plan Administrator and each other employee who acts in the capacity of an agent, delegate, or representative ("Plan Administration Employee") of the Plan Administrator against any and all losses, liabilities, costs and expenses incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened, or anticipated action, suit or other proceeding in which the Employee may be involved by having been a Plan Administration Employee.

Compliance with Federal Mandates

The Plan is designed to comply to the extent possible with the requirement of all applicable laws, including but not limited to: COBRA, USERRA, HIPAA, the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), WHCRA, FMLA, the Mental Health Parity and Addiction Equity Act of 2008, PPACA, HITECH, Michelle's Law, and Title I of GINA.

Non-discrimination

In accordance with IRC Section 125, the Plan is intended not to discriminate in favor of Key Employees (as defined in Code Section 416) or Highly Compensated Individuals as to eligibility to participate; or in favor of Highly Compensated Participants as to contributions and benefits, nor to provide more statutory nontaxable benefits than permitted under applicable law to Key Employees. The Plan Administrator will take such actions necessary to

ensure that the Plan does not discriminate in favor of Key Employees, Highly Compensated Individuals, or Highly Compensated Participants.

Future of the Plan

The Company expects that the Plan will continue indefinitely. However, the Company has the sole right to amend, modify, suspend, or terminate all or part of the Plan at any time.

The Company may also change the level of benefits provided under the Plan at any time. If a change is made, benefits for claims incurred after the date the change takes effect will be paid according to the revised Plan provisions. In other words, once a change is made, there are no rights to benefits based on earlier Plan provisions.

Claims Procedures

This section describes what you must do to file or appeal a claim for services received in- and out-of-network.

In-Network Claims — Generally, no claim forms are necessary when you use in-network (participating) providers. Benefits for in-network covered services always are paid to the provider. If you pay the provider for a covered service, you must contact the provider to request a refund.

Out-of-Network Claims — If you use out-of-network (non-participating) providers, you might need to pay them when you receive services, including any coinsurance amount. You must then submit a claim form along with an itemized bill to the appropriate Claims Administrator. In most cases, the Claims Administrator will reimburse you directly. Occasionally, however, the Claims Administrator may reimburse the provider directly for covered expenses. If this happens to you and you already have paid your provider, you must request a refund from your provider.

The steps described below will guide you through the process of submitting your out-of-network claim. To obtain a form, contact your Claims Administrator. Complete a separate claim form for each covered family member who has expenses. If you already paid all or a portion of the fee to the provider, indicate the amount paid on the claim form.

For medical expenses, your Claims Administrator will send you an Explanation of Benefits (EOB) showing what the Plan covered. You may receive a bill from the provider for the remainder of the expense, which will be your responsibility to pay. Send the completed claim form to the appropriate Claims Administrator listed on your ID card along with any proof of payment (i.e., a receipt).

To be eligible for reimbursement under the Plan, a claim must be submitted within the time frames established by the Plan Administrator. Claims filed after that time may be reduced or denied. If you are unable to file a claim within the prescribed time frame, the Plan Administrator may elect to approve the claim after reviewing any extenuating circumstances if the claim is filed as soon as possible.

Time Frames for Submitting a Claim

Claims should be filed with the Claims Administrator in accordance to the following guidelines:

1. Participating Provider – submission time is based on the PPO Network contract.
2. Non-Participating Provider – within 120 days of the date charges for the services were incurred.
3. Member Submitted claims – within 120 days of the date charges for the services were incurred.

Claims filed later than the above dates may be declined or reduced unless:

1. It’s not reasonably possible to submit the claim in that time and
2. The claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

Time Frames for Processing a Claim

Claims are divided into urgent care claims, concurrent care claims, pre-service health claims, and post-service health claims. If you or your representative fail to follow the Plan's procedures for filing a claim or if you file an incomplete claim, the Plan will notify you or your representative of the failure according to the time frames shown in the following chart.

If an initial claim is denied in whole or in part, you or your representative will receive written notice from the Plan Administrator. This notice will include the reasons for denial, the specific Plan provision involved, an explanation of how claims are reviewed, the procedure for requesting a review of the denied claim, a description of any additional material or information that must be submitted with the appeal, and an explanation of why it is necessary. If your claim for benefits is denied, you or your representative may file a written appeal for review of a denied claim with the Plan Administrator.

The chart below shows the time frames for filing different types of claims with the Plan. If you have any questions about what type of claim you may have or the timing requirements that apply to your claim, please contact your Claims Administrator at the number shown on your ID cards.

Time Frames for Processing a Claim				
Claim Process	**Urgent Care Claim**	**Concurrent Care Claim**	**Pre-Service Health Claim**	**Post-Service Health Claim**
Claims Administrator determines initial claim is improperly filed (not filed according to Plan procedures) or is not complete	Within 24 hours after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Within 24 hours after receipt of request for extension of urgent concurrent care	Within 5 days after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Not applicable
Claims Administrator determines that you must submit additional information required to complete claim	Within 48 hours after receipt of notice that your claim is incomplete	Not applicable	Within 45 days after receipt of notice that additional information is required	Within 45 days after receipt of notice that additional information is required
Claims Administrator reviews claim and makes determination of:		For urgent care claims, within 24 hours after receipt of the claim, provided request is submitted at least 24 hours prior to expiration of prescribed period of time or number of treatments. If not submitted within 24 hours prior to expiration of prescribed period of time or number of treatments, not later than 72 hours after receipt of claim.* For non-urgent care claims, determination will be made within time frame designated for type of claim (pre- or post-service) and prior to expiration of prescribed period of time or number of treatments.*		
complete/proper claim	Within 48 hours after the earlier of: receipt of requested information, or at end of period allowed for you to provide information		Within 15 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information	Within 30 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information
initial claim	Within 24 hours of receipt of initial claim		Within 15 days of date initial claim is received	Within 30 days of date initial claim is received
Extension period,** if required due to special circumstances beyond control of Claims Administrator	Not applicable	Not applicable	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 15-day period	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 30-day period

* A request for extension of treatment will be deemed to be an initial claim. A reduction or termination of approved, ongoing treatment will be deemed to be an adverse claim decision. If the Claims Administrator makes an adverse decision, you will be notified of the reduction/termination within a time frame that allows you to submit an appeal and have a determination on the appeal prior to the expiration of the prescribed period of time or number of treatments.

** Whenever an extension is required, the Plan must notify you before the current determination period expires. The notice must state the circumstances requiring the extension and the date a determination is expected to be made.

How to Appeal a Claim

To appeal a denied claim or to review administrative documents pertinent to the claim, you or your representative must send a written request to the Plan. You may also appeal the Plan's decision to rescind your coverage due to fraud or intentional misrepresentation of material fact. The time frames for appealing a claim are shown in the following chart.

If you or your representative submit an appeal, state why you think your claim should be reviewed and include any data, documents, questions, or comments, along with copies of itemized bills and claim forms relating to your claim. You may request, free-of-charge, copies of all documents, records, and other information relevant to your claim. A reviewer who did not make the initial claim determination will be responsible for reviewing your appeal. Also, you will be notified of any expert advice obtained on behalf of the Plan in reviewing the denied claim, regardless of whether such advice was relied upon in reviewing your claim. Such experts will not be individuals who were consulted in making the initial claim determination.

Time Frames for Appealing Denied Claims

Appeal Process	Urgent Care Claim	Concurrent Care Claim	Pre-Service Health Claim	Post-Service Health Claim
You may submit an appeal of denied initial claim to the Claims Administrator	Within 180 days of receiving notice of denied claim	You will be notified of reduction or termination of benefit in time to submit appeal and receive determination before benefit ends	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
Claims Administrator reviews your first appeal and makes determination	Within 72 hours after appeal is received	Prior to reduction or termination of benefit	Within 15 days of date appeal is received	Within 30 days of date appeal is received
You may submit a second appeal to the Plan Administrator	N/A	N/A	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
The Plan Administrator reviews your second appeal and makes final determination	N/A	N/A	Within 15 days of date appeal is received	Within 30 days of date appeal is received

You will be notified of the Plan Administrator's decision in writing. If your claim is denied, the Plan Administrator will give you in writing the specific reason(s) that your claim was denied, the specific reference to the Plan provisions on which the denial was based, any internal rules, guidelines, protocols, or similar criteria used as basis for the decision, a statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

The decision of the Plan Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law.

Exhaustion Required

If you do not file a claim, follow the claims procedures, or appeal a claim within the timeframes permitted, you will give up all legal rights, including your right to file suit, as you will not have exhausted your internal administrative appeal rights. Participants or claimants

must exhaust all remedies available to them under the Plan before bringing legal action. Additionally, legal action may not be brought against the Plan more than one year after a final decision on appeal has been reviewed under the Plan.

External Review Rights

If, after exhausting your internal appeals, you are not satisfied with the determination made by the Claims Administrator, you may be entitled to request an external review of the Claims Administrator's decision. You will be notified in writing that your claim is eligible for an external review and you will be informed of the time frames and the steps necessary to request an external review. In most cases, you must complete all levels of the internal claims and appeal procedure before you can request a voluntary external review.

External review is only available for adverse benefit determinations that involve medical judgment or a rescission of coverage.

If you decide to seek external review, an independent external review organization (an "IRO") will be assigned your claim. The IRO does not have to give deference to any earlier claims and appeals decisions, but it must observe the written terms of the Plan document. In other words, the IRO is not bound by any previous decision made on your claim. The ultimate decision of the IRO will be binding on you, the Claims Administrator and the Plan.

There are two types of external review:

- Standard external review
- Expedited external review

You or your representative may request a standard external review, or an expedited external review in urgent situations, by following the directions in the determination letter. A request for an external review must be made within four months after the date you received Claims Administrator's decision.

Standard External Review

A standard external review involves the following steps:

- The Claims Administrator performs a preliminary review.
- The Claims Administrator refers the review request to the IRO.
- The IRO makes a decision.

Within the applicable timeframe after receipt of the request, the Claims Administrator will complete a preliminary review to determine whether you meet all of the following requirements:

- You were covered under the Plan at the time the health care item or service was provided (or requested for a pre-service claim).
- The adverse benefit determination does not relate to your failure to meet the Plan's eligibility criteria.
- You have exhausted the Plan's applicable internal appeals process (unless the Claims Administrator did not adhere to the claims and appeals requirements).
- You have provided all the information and forms required so that the Claims Administrator may process your external review request.

After the Claims Administrator completes the preliminary review, it will issue a notification in writing to you. If your request is complete but not eligible for external review, the Claims Administrator's notice will provide (1) the reasons your request is ineligible and (2) contact information for the Employee Benefits Security Administration. If your request is not complete, the notice will describe the missing information or materials. The Claims Administrator will then allow you to complete the request for external review before the end of the original four-month filing period or within 48 hours, whichever is later.

If the request is eligible for external review, the Claims Administrator will assign an IRO to conduct the review and provide the IRO with the materials considered during the internal appeals process. The IRO will timely notify you in writing to (1) confirm your request is eligible for external review and (2) inform you that you may submit in writing, within ten business days following the date of receipt, additional information that the IRO should consider when conducting the external review. The IRO will forward any additional information you provide to the Claims Administrator so that it may consider whether to approve your claim based on the new information.

The IRO will provide written notice of its determination within 45 days after it receives the request for the external review. The IRO will deliver the notice of its determination to you and the Claims Administrator, and it will include the clinical basis for the determination.

If the IRO's decision reverses the Claims Administrator's determination, the Plan will provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the IRO's determination is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the health care item or service.

Expedited External Review

An expedited external review is similar to a standard external review. The main difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive any of the following:

- An adverse benefit determination involving a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if you followed the guidelines for an expedited internal appeal and you have filed a request for an expedited internal appeal;
- A final internal adverse benefit determination involving a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if you followed the guidelines for a standard external review; or
- A final internal adverse benefit determination involving an admission, availability of care, continued stay, or a health care item or service for which you received emergency services, but have not been discharged from the facility.

Immediately upon receipt of your request, the Claims Administrator will determine whether the request is eligible for expedited external review and will immediately send you a notice of its eligibility determination.

If the Claims Administrator determines that your request is eligible for an expedited external review, the Claims Administrator will assign an IRO. The IRO will render a decision as quickly as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, the assigned IRO will provide you, the Claims Administrator, and the Plan with written notification of its decision within 48 hours.

For additional information about the external IRO process, contact the Claims Administrator at the telephone number shown on your ID card.

Coordination of Benefits

This section describes how benefits under this Plan are coordinated with other benefits to which you or a covered dependent might be entitled.

Non-Duplication of Benefits / Coordination of Benefits

If a Plan participant is covered by another employer's plan, the two plans work together to avoid duplicating payments. This is called non-duplication or coordination of benefits.

Your medical benefits are coordinated with benefits from:

- other employers' plans;
- certain government plans; and
- motor vehicle plans when required by law.

Non-duplication of benefits does not apply to prescription drug benefits.

How Non-Duplication Works

When an expense is covered by two plans, the following apply:

- the primary plan is determined and pays the full amount it normally would pay;
- the secondary plan calculates the amount it normally would pay and then pays any portion of that amount not paid by the primary plan (but not to exceed 100% of charges); and
- you pay any remaining expenses.

If another plan is primary and this plan is secondary, the Plan will calculate the amount it would pay as if there were no other coverage, subtract the amount payable by the primary plan, and then pay any eligible remaining amount.

Determining Primary and Secondary Plans

Primary and secondary plans are determined as follows.

- A plan that does not contain a coordination of benefits provision is primary.
- If you are the employee, this Plan normally is primary when you have a covered expense.
- If your covered spouse is the patient, your spouse's company plan (if applicable) is primary. Your spouse should submit expenses to that plan first, wait for the payment, and then submit the claim under this Plan with copies of the expenses and the primary plan's Explanation of Benefits (EOB).
- When both parents' plans cover an eligible dependent child, the plan of the parent whose birthday (month and day) comes first in the calendar year is primary. For example, if your spouse's birthday is March 15 and your birthday is September 28, your spouse's plan is primary. If both parents were born on the same day, the plan of the parent who has had coverage in effect the longest will be primary. However, if the other plan does not have this birthday rule and, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.
- When parents who are legally separated or divorced both cover an eligible dependent child, the following rules apply.

- If the parents have joint custody and there is no court decree stating which parent is responsible for health care expenses, the birthday rule previously stated will apply.
- If one parent has custody, his or her plan is primary and the other parent's plan is secondary. If the parent with custody remarries, the stepparent's plan becomes secondary and will pay before the plan of the parent without custody (the third plan).
- If the remarried parent with custody has no health care coverage, the stepparent's plan is primary and the plan of the parent without custody is secondary.
- Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses and that parent has enrolled the child in his or her plan, that parent's plan is primary.
- When none of the previous rules applies, the plan that has covered the patient for the longer period is primary.

Coordination with Medicare

If you are actively employed after becoming eligible for Medicare, your coverage under the Plan will be coordinated with Medicare. Which plan pays first ("primary") is determined by whether your Employer is considered a small or large group employer. Generally, for large group employer plans, Medicare requires the employer's plan to pay first and Medicare pays second ("secondary"). You should check with your Employer if you become eligible for Medicare while employed to determine if your Employer's coverage will be primary or secondary.

The Plan also coordinates with Medicare as follows.

- End-stage renal disease—If you or a covered dependent is eligible for Medicare due to end-stage renal disease, this Plan will be primary for the first 30 months of dialysis treatment; after this period, this Plan will be secondary to Medicare for this disease only.
- Mandated coverage under another group plan—If a person is covered under another group plan and Federal law requires the other group plan to pay primary to Medicare, this Plan will be tertiary (third payer) to both the other plan and Medicare.

Coordination with Auto Insurance Plans

First-party auto insurance coverage is considered primary. This Plan coordinates its benefits with the first-party benefits from an auto insurance plan without regard to fault for the same covered expense.

If you or your covered dependent incurs covered expenses as a result of an automobile accident (either as driver, passenger, or pedestrian), the amount of covered expenses that the Plan will pay is limited to:

- any deductible under the automobile coverage;
- any co-payment under the automobile coverage;

- any expense properly denied by the automobile coverage that is a covered expense; and
- any expense that the Plan is required to pay by law.

For Maximum Benefit

Generally, claims should be filed promptly with all plans to receive the maximum allowable benefits. You must supply the claim information needed to administer coordination of benefits. If you receive more payment than you should when benefits are coordinated, you will be expected to repay any overpayment.

Subrogation and Reimbursement

If you or your dependent receives benefits in excess of the amount payable under the Plan, the Company has a right to subrogation and reimbursement, as defined in the following sections.

Right of Recovery

The Plan has the right to recover benefits it has paid on your or your dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period you were meeting the plan year deductible; or
- advanced during the time period you were meeting the out-of-pocket maximum for the plan year.

Benefits paid because you or your dependent misrepresented facts also are subject to recovery. If the Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested; or
- reduce a future benefit payment for you or your dependent by the amount of the overpayment.

Right to Subrogation

The right to subrogation means the Plan is substituted to any legal claims that you may be entitled to pursue for benefits that the Plan has paid. Subrogation applies when the Plan has paid benefits for a sickness or injury for which a third party is considered responsible (e.g., an insurance carrier if you are involved in an auto accident).

The Plan will be subrogated to, and will succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and benefits the Plan has paid on your behalf relating to any sickness or injury caused by any third party.

Right to Reimbursement

The right to reimbursement means that if a third party causes a sickness or injury for which you receive a settlement, judgment, or other recovery, you must use those proceeds to return to the Plan 100 percent of any benefits you received for that sickness or injury.

Third Parties

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a sickness, injury, or damages, or who is legally responsible for the sickness, injury, or damages; or
- any person or entity who is or may be obligated to provide you with benefits or payments under:
    - underinsured or uninsured motorist insurance;
    - medical provisions of no-fault or traditional insurance (auto, homeowners, or otherwise);
    - Workers' Compensation coverage; or
    - any other insurance carrier or third party administrator.

When This Provision Applies To You

If you or any of your covered dependents, or anyone who receives benefits under this plan, becomes ill or is injured and is entitled to receive money from any source, including but not limited to any party's liability insurance or uninsured/underinsured motorist proceeds, then the benefits provided or to be provided by the Plan will be paid only if you fully cooperate with the terms and conditions of the Plan.

As a condition of receiving benefits under this Plan, you agree that acceptance of benefits for you and/or your dependents is constructive notice of this provision in its entirety and agree to reimburse the Plan 100 percent of any benefits provided or to be provided without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. You further agree that the Plan shall have an equitable lien on any funds received by you or your dependents, and/or you or your attorney, if any, from any source for any purpose and shall be held in trust until such time as the obligation under this provision is fully satisfied. If you or your dependent retains an attorney, then you and your dependents agree to only retain one who will not assert the Common Fund or Made-Whole Doctrines. Reimbursement shall be made immediately upon collection of any sum(s) recovered regardless of its legal, financial or other sufficiency. If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds.

You or your covered dependent agrees to sign any documents requested by the Plan including but not limited to a reimbursement and/or subrogation agreement, or accident questionnaire, as the Plan or its agent(s) may request. You and your covered dependent also agree to furnish any other information as may be requested by the Plan or its agent(s). Failure to sign and return any requested documentation or information may result in the Plan's denial of claims. However, such failure or refusal to execute such agreements or furnish information does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement. Any settlement or recovery received, regardless of how characterized, shall first be deemed for reimbursement of expenses paid by the Plan. Any excess after 100 percent reimbursement to the Plan may be divided between you or your dependent (the covered person) and your attorney if applicable. Any accident-related claims made after satisfaction of this obligation shall be paid by you or your dependent and not the Plan.

You and/or your covered dependents agree to take no action which in any way prejudices the rights of the Plan. If it becomes necessary for the Plan to enforce this provision by initiating any action against you or your dependent (the covered person), then you and/or your dependent agree to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

The Plan Administrator has sole discretion to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary. Furthermore, the Plan may reduce or deny any future benefits by the amount of any recovery received, but not reimbursed, by you or your covered dependent for an accident or injury for which the Plan paid benefits.

If you and/or your covered dependent take no action to recover money from any source, then you and/or your dependent agree to allow the Plan to initiate its own direct action for reimbursement.

Your HIPAA/COBRA Rights

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. These rules are called the HIPAA Privacy Rules.

You will receive a “Notice of Privacy Practices” from the Administrator(s) and/or Insurer(s) that contains information about how your individually identifiable health information is protected under the HIPAA Privacy Rules and who you should contact with questions or concerns.

The HIPAA Privacy Rules apply to group health plans. These plans are commonly referred to as “HIPAA Plans” and are administered to comply with the applicable provisions of HIPAA. PHI is individually identifiable information created or received by HIPAA Plans that relates to an individual’s physical or mental health or condition, the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper or oral. When PHI is in electronic form it is called “ePHI.”

The HIPAA Plans may disclose PHI to the Plan Sponsor only as permitted under the terms of the Plan, or as otherwise required or permitted by HIPAA. The Plan Sponsor agrees to use and disclose PHI only as permitted or required by the HIPAA Privacy Rules and the terms of the Plan.

The HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose enrollment and disenrollment information to the Plan Sponsor. Also, the HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the information for the purposes of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending or terminating the Plan. “Summary Health Information” means information that summarizes the claims history, claims expenses or types of claims experienced by individuals covered under the HIPAA Plans and has almost all individually identifying information removed. The HIPAA Plans may also disclose PHI to the Plan Sponsor pursuant to a signed authorization that meets the requirements of the HIPAA Privacy Rules.

In addition, the HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose PHI to the Plan Sponsor for plan administration purposes. Plan administration purposes means administration functions performed by the Plan Sponsor on behalf of the HIPAA Plans, such as claims processing, coordination of benefits, quality assurance, auditing and monitoring. Plan administration purposes do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor or any employment-related actions or decisions.

The Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information, Summary Health Information and information disclosed pursuant to a valid HIPAA authorization) disclosed to it by the HIPAA Plans (or an Insurer with respect to the HIPAA Plans), the Plan Sponsor will:

- Not use or further disclose the information other than as permitted or required by the Plan or as required by law;
- Ensure that any agents, including subcontractors, to whom it provides PHI received from the HIPAA Plans agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
- Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- Report to the HIPAA Plans any use or disclosure of PHI of which it becomes aware that is inconsistent with the permissible uses or disclosures;
- Make PHI available in accordance with the individual rights of access under the HIPAA Privacy Rules;
- Make an individual's PHI available for amendment, and incorporate any amendments, as required by the HIPAA Privacy Rules;
- Make available the information required to provide an accounting of disclosures to individuals, as required by the HIPAA Privacy Rules;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the HIPAA Plans available to the Secretary of the Department of Health and Human Services for purposes of determining compliance with HIPAA's requirements;
- If feasible, return or destroy all PHI received from the HIPAA Plans that the Plan Sponsor still maintains in any form and retain no copies of this information when no longer needed for the purpose for which disclosure was made, except that, if this return or destruction is not feasible, limit further uses or disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure adequate separation between the HIPAA Plans and the Plan Sponsor is established.

In addition, the Plan Sponsor will reasonably and appropriately safeguard ePHI (other than enrollment/disenrollment information, Summary Health Information and information disclosed pursuant to a valid HIPAA authorization) that is created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the HIPAA Plans. The Plan Sponsor will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the HIPAA Plans;
- Ensure that adequate separation between the HIPAA Plans and the Plan Sponsor is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the HIPAA Plans any security incident of which it becomes aware.

Continuing Health Care Coverage through COBRA

In special situations, you or your covered dependent(s) may continue health care coverage at your or your dependent's expense when it otherwise would end. The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows a continuation of health care coverage to qualified beneficiaries for a specific length of time. This section provides an overview of COBRA continuation coverage. The coverage described may change as permitted or required by applicable law. When you first enroll in coverage, you will receive from the Plan Administrator/COBRA Administrator your initial COBRA notice. This notice and subsequent notices you receive will contain current requirements applicable for you to continue coverage.

The length of COBRA continuation coverage (COBRA coverage) depends on the reason that coverage ends, called the "qualifying event." These events and the applicable COBRA continuation period are described below.

If you and/or your eligible dependent(s) choose COBRA coverage, the Company is required to offer the same medical and prescription drug coverage that is offered to similarly situated employees. Proof of insurability is not required to elect COBRA coverage. In other words, you and your covered dependents may continue the same health care coverage you had under the Plan before the COBRA qualifying event.

If you have a new child during the COBRA continuation period by birth, adoption, or placement for adoption, your new child is considered a qualified beneficiary. Your new child is entitled to receive coverage upon his or her date of birth, adoption, or placement for adoption, provided you enroll the child within 30 days of the child's birth/adoption/placement for adoption. If you do not enroll the child under your coverage within 30 days, you will have to wait until the next open enrollment period to enroll your child.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

For more information about the Marketplace, visit www.HealthCare.gov.

COBRA Qualifying Events and Length of Coverage

Each person enrolled in benefits will have the right to elect to continue health benefits upon the occurrence of a qualifying event that would otherwise result in such person losing health benefits. Qualifying events and the length of COBRA continuation are as follows:

18-Month Continuation

Health care coverage for you and your eligible dependent(s) may continue for 18 months after the date of the qualifying event if your:

- employment ends for any reason other than gross misconduct; or
- hours of employment are reduced.

18-Month Continuation Plus 11-Month Extension

If you or your eligible dependent is disabled at the time your employment ends or your hours are reduced, the disabled person may receive an extra 11 months of coverage in addition to the 18-month continuation period (for a total of 29 months of coverage). If the individual entitled to the disability extension has non-disabled family members who have COBRA coverage due to the same qualifying event, those non-disabled family members will also be entitled to the 11-month extension, including any child born or placed for adoption within the first 60 days of COBRA coverage.

The 11-month extension is available to any COBRA participant who meets all of the following requirements:

- he or she becomes disabled before or within the first 60 days of the initial 18-month coverage period; and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) within 60 days of the date on the Social Security Administration determination letter, and provides a copy of the disability determination; and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) before the initial 18-month COBRA coverage period ends.

You must also notify the Plan Administrator (or its designated COBRA Administrator) within 30 days of the date Social Security Administration determines that you or your dependent is no longer disabled.

36-Month Continuation

Coverage for your eligible dependent(s) may continue for up to 36 months if coverage is lost due to your:

- death;
- divorce or legal separation;
- eligibility for Medicare coverage; or
- dependent child's loss of eligible dependent status under this Plan

Note: If any of these events (other than Medicare entitlement) occur while your dependents are covered under COBRA (because of an 18-month or 18-month plus extension qualifying event), coverage for the second qualifying event may continue for up to a total of 36 months from the date of the first COBRA qualifying event. In no case, however, will COBRA coverage be continued for more than 36 months in total.

If you become eligible for Medicare before a reduction in hours or your employment terminates, coverage for your dependents may be continued for up to 18 months from the date of your reduction in hours or termination of employment, or for up to 36 months from the date you became covered by Medicare, whichever is longer.

COBRA Notifications

If you or your covered dependents lose coverage under the Plan because your employment status changes, you become entitled to Medicare, or you die, the Plan Administrator (or its designated COBRA administrator) will automatically provide you or your dependents with additional information about COBRA continuation coverage, including what actions you must take by specific deadlines.

If your covered dependent loses coverage as a result of your divorce, legal separation or a dependent child's loss of eligibility under the Plan, you or your dependent must notify the Company within 60 days of the qualifying event. The Plan Administrator (or its designated COBRA administrator) will automatically send you or your dependent, as applicable, COBRA enrollment information. If you or your dependent fails to provide notification of the event within 60 days, you or your dependent forfeits all continuation of coverage rights under COBRA. To continue COBRA coverage, you and/or your eligible dependents must elect and pay the required cost for COBRA coverage.

Cost of COBRA Coverage

You or your eligible dependent pays the full cost for health care coverage under COBRA, plus an administrative fee of two percent, or 102 percent of the full premium cost, except in the case of an 11-month disability extension where you must pay 150 percent of the full premium cost for coverage.

COBRA Continuation Coverage Payments

Each qualified beneficiary may make an independent coverage election. You must elect COBRA coverage by completing and returning your COBRA enrollment form as instructed in your enrollment materials within 60 days of the date you receive information about your COBRA rights or, if later, the date of your qualifying event.

The first COBRA premium payment is due no later than 45 days from the date COBRA coverage is elected. Although COBRA coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full premium payment is received. Each month's premium is due prior to the first day of the month of coverage. You or your dependent is responsible for making timely payments.

If you or your dependent fails to make the first payment within 45 days of the COBRA election, or subsequent payments within 30 days of the due date (the grace period), COBRA coverage will be canceled permanently, retroactive to the last date for which premiums were paid. COBRA coverage cannot be reinstated once it is terminated. Other important information you need to know about the required COBRA coverage payments follows.

COBRA premium payments that are returned by the bank for insufficient funds will result in termination of your COBRA coverage if a replacement payment in the form of a cashier's check, certified check, or money order is not made within the grace period.

COBRA premium payments must be mailed to the address indicated on your premium notice. Even if you do not receive your premium notice, it is your responsibility to contact the COBRA administrator. Your COBRA coverage will end if payment is not made by the due date on your notice. It is your responsibility to ensure that your current address is on file.

You may be eligible for state or local assistance to pay the COBRA premium. For more information, contact your local Medicaid office or the office of your state insurance commissioner.

How Benefit Extensions Impact COBRA

If you have a qualifying event that could cause you to lose your coverage, the length of any benefit extension period is generally considered part of your COBRA continuation coverage

period and runs concurrently with your COBRA coverage. (Also see “Coverage While You Are Not at Work” in the Plan Overview for additional information.)

If you take a leave under the Family and Medical Leave Act (FMLA), COBRA begins;

- at the end of the leave if you do not return after the leave; or
- on the date of termination if you decide to terminate your employment during the leave.

When COBRA Coverage Ends

COBRA coverage for a covered individual will end when any of the following occur:

- The premium for COBRA coverage is not paid on a timely basis (monthly payments must be postmarked within the 30-day grace period, your initial payment must be postmarked within 45 days of your initial election).
- The maximum period of COBRA coverage, as it applies to the qualifying event, expires.
- The individual becomes covered under any other group medical plan.
- The individual becomes entitled to Medicare.
- The Company terminates its group health plan coverage for all employees.
- Social Security determines that an individual is no longer disabled during the 11-month extension period.

Definitions

Accident

An unexpected or reasonably unforeseen occurrence or event that is definite as to time and place.

Actively at Work

A participant is considered actively at work if he or she:

- is presently at work on a scheduled workday performing the regular duties of his or her job for the hours he or she is normally scheduled to work; or
- was present at work on the last scheduled working day before:
    - a scheduled vacation;
    - an absence due to a paid holiday, paid jury or witness day, or a paid bereavement day;
    - a scheduled day off within the participant's working schedule; or
    - an absence excused by the Company.

Approved Clinical Trial

A phase I, phase II, phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection or treatment of cancer or other life-threatening disease or condition and is federally funded through a variety of entities or departments of the federal government, is conducted in connection with an investigational new drug application reviewed by the Food and Drug Administration, or is exempt from investigational new drug application requirements.

COBRA

The Consolidated Omnibus Budget Reconciliation Act. This Federal law allows a continuation of health care coverage in certain circumstances.

Coinsurance

The percentage of the cost of covered expenses a participant must pay after meeting any applicable deductible.

Complete Claim (Proper Claim)

A previously incomplete claim for which a participant has submitted the missing or additional information required for the Plan to make a determination.

Concurrent Care Claim

A claim for a benefit that involves an ongoing course of treatment.

Co-payment

The fixed dollar amount of covered expenses a participant must pay before Plan pays.

Deductible

The dollar amount (for individual or family) a participant must pay each year before the Plan begins to pay benefits.

Doctor/Physician

A doctor of medicine (M.D.) or doctor of osteopathy (D.O.). The term also includes a chiropractor (D.C.), dentist (D.M.D. or D.D.S.), or a podiatrist (D.P.M.). In all cases, the

person must be legally qualified and licensed to perform a service at the time and place of the service.

Eligible Provider

Any practitioner or facility offering covered services and acting within the scope of the appropriate license; examples include a licensed doctor, osteopath, podiatrist, chiropractor, hospital, or laboratory.

Employee

A person who works for the Company in an employer-employee relationship.

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) is a Federal law that provides for an unpaid leave of absence for up to 12 weeks per year for:

- the birth or adoption of a child or placement of a foster child in a participant's home;
- the care of a child, spouse or parent (not including parents-in-law), as defined by Federal law, who has a serious health condition;
- a participant's own serious health condition; or
- any qualifying exigency arising from an employee's spouse, son, daughter, or parent being a member of the military on "covered active duty". Additional military caregiver leave is available to care for a covered service member with a serious injury or illness who is the spouse, son, daughter, parent, or next of kin to the employee.

Generally, you are eligible for coverage under FMLA if you have worked for your Company for at least one year; you have worked at least 1,250 hours during the previous 12 months; your Company has at least 50 employees within 75 miles of your worksite; and you continue to pay any required premium during your leave as determined by the Company. You should contact the Company with any questions you have regarding eligibility for FMLA coverage or how it applies to you.

Formulary

A list of prescription drugs that represent safe, effective therapeutic medications covered by the Plan.

Genetic Information

Genetic information includes information about genes, gene products, and inherited characteristics that may derive from an individual or family member. This includes information regarding carrier status or information derived from laboratory tests that identify mutations in specific genes or chromosomes, medical examinations, family histories, or direct analysis of genes or chromosomes.

GINA

The Genetic Information Nondiscrimination Act of 2008, as amended.

HIPAA

Health Insurance Portability and Accountability Act of 1996, as amended.

HITECH

The Health Information Technology for Economic and Clinical Health Act, as amended.

In-Network Provider

A health care professional or facility that is contracted by the Plan to provide health care benefits under the Plan.

Leased Employee

Leased employee as defined in the Internal Revenue Code, section 414(n), as amended.

Managed Care

A type of health care delivery system that combines doctor choice and access with lower costs, less paperwork, and prescribed standards for medically necessary treatment.

Medicare

The program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

Network

A group of doctors, hospitals, and other providers contracted by the Plan to provide health care services for the Plan's members at agreed-upon rates.

Network Pharmacy

A pharmacy contracted by the Plan to provide prescription drug benefits under the Plan.

NMHPA

The Newborns' and Mother's Health Protection Act of 1996, as amended. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Out-of-Pocket Maximum

The maximum amount a participant pays for covered medical expenses (including expenses for covered dependents) in a Plan year. When the out-of-pocket maximum is reached, the Plan pays 100% of eligible covered expenses for the rest of the plan year.

Participant

An eligible employee who elects to participate in the Plan by completing the necessary enrollment forms.

Post-Service Health Claim

A claim for a benefit under the Plan that is not a pre-service claim.

PPACA

The Patient Protection and Affordable Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

Pre-Service Health Claim

A claim for a benefit that, under the terms of the Plan, requires a participant to receive, in whole or in part, prior approval from the Plan as a condition to receive the benefit.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)

Any court order that: 1) provides for child support with respect to the employee's child or directs the employee to provide coverage under a health benefit plan under a state domestic relations law, or 2) enforces a law relating to medical child support described in the Social Security Act, Section 1908, with respect to a group health plan. A QMCSO or an NMSN also may be issued through an administrative process established under state law. A participant must notify the Plan Administrator if he or she is subject to a QMCSO or an NMSN.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

A Federal law covering the rights of participants who have a qualified uniformed services leave.

Urgent Care Claim

A claim for medical treatment which, if the regular time periods observed for claims were adhered to, 1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or 2) would, in the opinion of a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed. Any claim that a physician with knowledge of the claimant's medical condition determines to be a "claim involving urgent care" will be deemed to be an urgent care claim. Otherwise, whether a claim is an urgent care claim or not will be determined by an individual acting on behalf of the Plan, and applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

WHCRA

The Women's Health and Cancer Rights Act of 1998, as amended. Your medical coverage under the Plan includes coverage for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your covered dependent who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for: 1) All stages of reconstruction of the breast on which the mastectomy was performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; 3) Prostheses; and 4) Treatment of physical complications at all stages of mastectomy, including lymphedema.

Adoption of the Plan

(Passport Select Plan)

The Kenmore Town of Tonawanda Union-Free School District Passport Select Plan, as stated herein, is hereby adopted as of 07/01/2015. This document constitutes the basis for administration of the Plan.

IN WITNESS WHEREOF, the parties have caused this document to be executed on this 11 day of MARCH, 2016

BY: _____

TITLE: PAYROLL/BENEFITS ADMINISTRATOR

PASSPORT SELECT
SCHEDULE OF BENEFITS

PASSPORT SELECT		
Benefit Description	**In-Network**	**Out-of-Network**
Deductible	$500 Individual $1,000 Family On an Individual policy, the individual in-network deductible must be met before IH provides reimbursement for covered in-network services. On a family policy, once an individual member meets the individual in-network deductible, the deductible is satisfied for that member. However, additional family members must satisfy the individual in-network deductible before IH provides reimbursement for covered in-network services.	$2,000 Individual $4,000 Family The out-of-network deductible applies to covered out-of-network medical services and does NOT apply to any applicable pharmacy coverage. On a Individual policy, the individual out-of-network deductible must be met before IH provides reimbursement for covered out-of-network services. On a Family policy, once a family member meets the individual out-of-network deductible, the deductible is satisfied for that member. However, additional family members must satisfy the family out-of-network deductible before IH provides reimbursement for covered out-of-network services.
Out-of-Pocket Maximum	$5,000 Individual $10,000 Family Separate Pharmacy out of pocket maximum $1,600 Individual/$3,200 Family Pharmacy member liability applies separately to the Pharmacy out-of-pocket maximum The deductible, copayment, coinsurance applies to the combined out-of-pocket max. On an Individual policy, the individual combined out-of-pocket max must be met before IH provides 100% reimbursement of the allowed amount for covered in-network or out-of-network services. On a Family policy, once a family member meets the individual in-network out-of-pocket max IH will provide 100% reimbursement of the allowed amount for covered in-network services. However, additional family members must satisfy the family in-network out-of-pocket max before IH provides 100% reimbursement of the allowed amount for covered in-network services. Note: Once the combined out-of-pocket max is met, the member will not be responsible for any in-network or out-of-network deductible, copayments or coinsurance. 100% reimbursement of the allowed amount for covered in-network services	
Coinsurance	Plan pays 75%/member pays 25% unless otherwise noted	Plan pays 60%/member pays 40% unless otherwise noted
Usual, Customary and Reasonable Rate	Not applicable	80th Percentile. Covered Person may be balanced billed for the difference between UCR and billed charges. If UCR rate is not available and IH cannot negotiate a rate, billed charges apply.
Pre-Certification	**Call Independent Health's Utilization Management Department at (716) 631-2661 or (800) 257-2753.**	
Penalty for Failure to Pre-Certify	The member is responsible for the payment of 50% of the eligible expenses up to a maximum of $500 for each admission/outpatient service. Additional payments may apply. This additional percentage is a PENALTY and does not apply to the out-of-pocket maximum, Deductible and Coinsurance.	
Coordination Of Benefits Procedures	Refer to the Coordination of Benefits Section in the SPD for details	

PASSPORT SELECT				
Benefit Description	**IN-NETWORK (Participating)**	**Member Precertification Required**	**OUT-OF-NETWORK (Non-Participating)**	**Member Precertification Required**

PASSPORT SELECT				
Benefit Description	**IN-NETWORK (Participating)**	**Member Precertification Required**	**OUT-OF-NETWORK (Non-Participating)**	**Member Precertification Required**
ACUPUNCTURE – NOT COVERED				
ALCOHOL/SUBSTANCE ABUSE (ACUTE CONDITIONS ONLY)				
Inpatient Facility Detox Only	Plan pays 75% after Deductible.	**Y**	Plan pays 60% after Deductible.	**Y**
Inpatient Rehabilitation Facility	Plan pays 75% after Deductible.	**Y**	Plan pays 60% after Deductible.	**Y**
Inpatient Rehabilitation Physician	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Outpatient	Plan pays 75% after Deductible..	N	Plan pays 60% after Deductible.	N
Family Therapy	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Residential Treatment	Plan pays 75% after Deductible.	**Y**	Plan pays 60% after Deductible.	**Y**
ALLERGY TESTING & TREATMENT				
Allergy Testing & Treatment	Plan pays 100% after Office Visit Copayment.	N	Plan pays 60% after Deductible.	N
Allergy Serum	Plan pays 100%.	N	Plan pays 60% after Deductible.	N
Rast Testing	Plan pays 100%.	N	Plan pays 60% after Deductible.	N
AMBULANCE				
Ambulance	Plan pays 100% after deductible and $250 Copayment.	N	Covered as In-Network Benefit	N/A
ANESTHESIA				
Inpatient	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Outpatient	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N

PASSPORT SELECT				
Benefit Description	**IN-NETWORK (Participating)**	**Member Precertification Required**	**OUT-OF-NETWORK (Non-Participating)**	**Member Precertification Required**
Pain Management	See Outpatient Surgical Procedures			
ARTIFICIAL INSEMINATION				
Artificial Insemination	Coverage is pursuant to the eligibility requirements and conditions outlined by the NYS Infertility mandate. Applicable member liability based on services rendered.	N	Coverage is pursuant to the eligibility requirements and conditions outlined by the NYS Infertility mandate. Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N
AUTISM				
Assessment for Autism	Plan pays 100% after Deductible and $25 Copayment.	N	Plan pays 60% after Deductible.	N
Applied Behavioral Analysis (ABA)	Not Covered.	N	Not Covered.	N
ABA Treatment	Not Covered.	N	Not Covered.	N
Assistant Communication Devices (ACD)	Not Covered.	N	Not Covered.	N
AUTOLOGOUS BLOOD				
Autologous Blood	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
CARDIAC REHABILITATION (LIMIT 36 VISITS PER PLAN YEAR. IN-NETWORK PLUS OUT-OF-NETWORK SERVICES COMBINED EQUALS TOTAL BENEFIT)				
Cardiac Rehabilitation	Plan pays 75% after Deductible. Covered following a heart transplant, Congestive Heart Failure, bypass surgery or a myocardial infarction.	N	Plan pays 60% after Deductible. Covered following a heart transplant, Congestive Heart Failure, bypass surgery or a myocardial infarction.	N
CHEMOTHERAPY TREATMENT (CANCER)				
Chemotherapy Treatment (Cancer)	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
CHIROPRACTIC CARE				
Chiropractic Care	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N

PASSPORT SELECT				
Benefit Description	**IN-NETWORK (Participating)**	**Member Precertification Required**	**OUT-OF-NETWORK (Non-Participating)**	**Member Precertification Required**
CLINICAL TRIALS				
Clinical Trials	Only Routine Patient Costs of Standard Care covered based on where services rendered	**Y**N	Not Covered.	**Y**
CONTRACEPTIVES				
Contraceptives administered in the provider's office	Devices dispensed in the office covered in full as a medical benefit. For insertion, removal or fitting of device is covered in full. Injections (Depo Provera) administered in the office, covered in full. If an office visit is required for the management of a new or ongoing condition and an injection is given in conjunction with that visit, then subject to Deductible and Coinsurance.	N	Devices dispensed in the office covered as a Medical benefit. Subject to deductible and coinsurance up to eligible expenses and additional payments may apply. For insertion, removal or fitting of device, Subject to deductible and coinsurance up to eligible expenses and additional payments may apply. Injections administered in the office: Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N
Contraceptives self-administered/used by the member	See Pharmacy Benefit	N	See Pharmacy Benefit	N
COSMETIC SURGERY				
Cosmetic Surgery	Not Covered Covered when medically necessary for reconstructive surgery when incidental to or when it follows surgery resulting from trauma, infection or other diseases of the involved body part.	**Y**	Not Covered Covered when medically necessary for reconstructive surgery when incidental to or when it follows surgery resulting from trauma, infection or other diseases of the involved body part.	**Y**
DENTAL				
Preventive and Routine	Not Covered	N	Not Covered	N
Accidental Dental	Medically necessary dental services when necessitated by accidental injury to sound natural teeth are covered within twelve months of the accident.	**Y**	Covered as In-Network Benefit	**Y**
Congenital Disease and Anomaly	Member liability based on services rendered when deemed medically necessary.	**Y**	Member liability based on services rendered when deemed medically necessary.	**Y**
DIABETIC				
Insulin, Oral Agent (30 Day Supply)	Plan pays 100% after $25 Copayment or pharmacy copayment, whichever is less	N	Plan pays 60% after Deductible.	N

PASSPORT SELECT				
Benefit Description	**IN-NETWORK (Participating)**	**Member Precertification Required**	**OUT-OF-NETWORK (Non-Participating)**	**Member Precertification Required**
Diabetic Supplies (30 Day Supply)	Plan pays 100% after $25 Copayment.	N	Plan pays 60% after Deductible.	N
Diabetic Equipment (e.g. Blood Glucose Monitor)	Plan pays 100% after $25 Copayment.	N	Plan pays 60% after Deductible.	N
Diabetic Equipment Insulin Pump	Plan pays 100% after $25 Copayment.	N	Plan pays 60% after Deductible.	N
Diabetic Teaching	Plan pays 100%.	N	Plan pays 60% after Deductible.	N
DIAGNOSTIC TESTING				
Diagnostic Testing (e.g. EKG, Stress Tests, not Lab or X-rays)	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
DIALYSIS				
Outpatient Facility	Plan pays 75% after deductible.	N	Plan pays 60% after Deductible.	N
Outpatient Physician	Plan pays 75% after deductible.	N	Plan pays 60% after Deductible.	N
DURABLE MEDICAL EQUIPMENT (DME)				
Durable Medical Equipment (DME)	Plan pays 80% after deductible.	**Y**	Plan pays 50% after Deductible.	**Y**
ELECTROCONVULSIVE THERAPY (ECT) – SEE MENTAL HEALTH				
EMERGENCY CARE				
Emergency Room Facilit	Plan pays 100% after deductible and $100 Copayment Deductible and Copayment waived if admitted	N	Covered as In-Network Benefit	N
ER Physician/Provider	Plan pays 100% after deductible.	N	Covered as In-Network Benefit	N
ER Follow up Visit	Office visit or emergency room copayment may apply.	N	Covered as In-Network Benefit	N
Observation Beds – Facility	Plan pays 100% after Deductible and $100 Copayment Deductible and Copayment waived if admitted	N	Covered as In-Network Benefit	N

PASSPORT SELECT				
Benefit Description	**IN-NETWORK (Participating)**	**Member Precertification Required**	**OUT-OF-NETWORK (Non-Participating)**	**Member Precertification Required**
Observation Beds – Physician	Plan pays 100% after Deductible.	N	Covered as In-Network Benefit	N
HEARING				
Hearing Tests	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Evaluation and Fitting for Hearing Aids	Not Covered	N	Not Covered	N
Hearing Aids	Not Covered **Exception:** Cochlear Implant & Bone Anchored Hearing Aid BAHA is covered if medically necessary.	N	Not Covered **Exception:** Cochlear Implant & Bone Anchored Hearing Aid BAHA is covered if medically necessary.	N
HOME HEALTH CARE/ AIDE (LIMIT 40 VISITS PER PLAN YEAR. IN-NETWORK PLUS OUT-OF-NETWORK SERVICES COMBINED EQUALS THE TOTAL BENEFIT)				
Home Health Care/ Aide 1 Home Health Aide visit = up to 4 continuous hours	Plan pays 75% after Deductible.	**Y**	Plan pays 60% after Deductible.	**Y**
Private Duty Nursing	Not Covered	N	Not Covered	N/A
HOME INFUSION THERAPY (FOR ENTERNAL AND PARENTERAL SEE NUTRITIONAL SUPPLIES)				
Nursing Services/Visits	Plan pays 75% after Deductible.	**Y**	Plan pays 60% after Deductible.	**Y**
Medication	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Other Services (e.g. supplies and per diem items)	Plan pays 75% after Deductible.	**Y**	Plan pays 60% after Deductible.	**Y**
HOME VISITS				
Home Visits (other than Home Health Care or Home Infusion Therapy)	Plan pays 100% after Office Visit Copayment.	N	Plan pays 60% after Deductible.	N
HOSPICE (INCLUDES BEREAVEMENT COUNSELING)				
Advance Care Planning (this benefit includes the Caring Hearts Perinatal Program)	Plan pays 100%. Limit 6 visits Per Plan Year In-network plus Out-of-Network services combined equal the total benefit.	N	Plan pays 60% after Deductible. Limit 6 visits Per Plan Year In-network plus Out-of-Network services combined equal the total benefit.	N

PASSPORT SELECT				
Benefit Description	**IN-NETWORK (Participating)**	**Member Precertification Required**	**OUT-OF-NETWORK (Non-Participating)**	**Member Precertification Required**
Inpatient	Plan pays 100%.	N	Plan pays 60% after Deductible.	N
Outpatient (Home)	Plan pays 100%.	N	Plan pays 60% after Deductible.	N
HOSPITAL				
Hospital – Inpatient Facility	Plan pays 75% after Deductible.	**Y**	Plan pays 60% after Deductible.	**Y**
Hospital - Inpatient Medical Rehab Facility	Plan pays 75% after Deductible. Limit 45 days Per Plan Year In-network plus Out-of-Network services combined equal the total benefit.	**Y**	Plan pays 60% after Deductible. Limit 45 days Per Plan Year In-network plus Out-of-Network services combined equal the total benefit.	**Y**
IMMUNIZATIONS (IF DONE IN CONJUNCTION WITH AN OFFICE VISIT THEN OFFICE VISIT COPAY MAY APPLY)				
Adult Immunizations (19 years and over)	Plan pays 100%.	N	Plan pays 60% after Deductible.	N
Flu & Pneumonia Immunizations (19 and over)	Plan pays 100%.	N	Plan pays 60% after Deductible.	N
Hepatitis B Immunizations (19 and over)	Plan pays 100%.	N	Plan pays 60% after Deductible.	N
Travel Immunizations (19 and over)	Plan pays 100%.	N	Plan pays 60% after Deductible.	N
Well Child Immunizations (0-18 years) *ACIP = Advisory Committee for Immunization Practices*	Plan pays 100%.	N	Plan pays 60% after Deductible.	N
INFERTILITY				
Infertility	Plan payment based On services provided. Coverage is pursuant to the eligibility requirements and conditions outlined by the NYS Infertility mandate.	N	Plan pays 60% after Deductible. Coverage is pursuant to the eligibility requirements and conditions outlined by the NYS Infertility mandate.	N
INJECTIONS				
Injections – Office-Based (not self-administered)	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
LABORATORY & PATHOLOGY				

PASSPORT SELECT				
Benefit Description	**IN-NETWORK (Participating)**	**Member Precertification Required**	**OUT-OF-NETWORK (Non-Participating)**	**Member Precertification Required**
Laboratory & Pathology	Plan pays 100%.	N	Plan pays 60% after Deductible.	N
MAMMOGRAMS				
Professional Services	Plan pays 100%.	N	Plan pays 60% after Deductible.	N
Technical Services	Plan pays 100%.	N	Plan pays 60% after Deductible.	N
MASTECTOMY/POST-MASTECTOMY				
Breast Prosthesis	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Post Mastectomy Supplies (Bras)	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Reconstructive Surgery	See Hospital and Outpatient Surgical Benefit.	N	See Hospital and Outpatient Surgical Benefit.	N
MATERNITY CARE				
Breast Feeding/ Lactation Support	Plan pays 100%.	N	Plan pays 60% after Deductible.	N
Prenatal & Postnatal Visits *Note: If a visit is unrelated to Pregnancy, Covered Person liability may apply based on services rendered.*	Plan pays 100%. After initial Diagnosis	N	Plan pays 60% after Deductible.	N
Sonogram(s)	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Facility – Delivery	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Facility – Physician	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Newborn – Facility	Plan pays 100%.	N	Plan pays 60% after Deductible.	N
Newborn – Physician	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Home Visit (Resulting from early discharge)	Plan pays 100%.	N	Plan pays 60% after Deductible.	N

PASSPORT SELECT				
Benefit Description	**IN-NETWORK (Participating)**	**Member Precertification Required**	**OUT-OF-NETWORK (Non-Participating)**	**Member Precertification Required**
MEDICAL SUPPLIES				
Medical Supplies	Plan pays 75% after Deductible.	**Y**	Plan pays 60% after Deductible.	**Y**
MEDICAL EXPENDABLE SUPPLIES				
Medical Expendable Supplies	Plan pays 75% after Deductible. When in conjunction with authorized skilled nursing services in the home	**Y**	Plan pays 60% after Deductible. When in conjunction with authorized skilled nursing services in the home	**Y**
MENTAL HEALTH				
Electroconvulsive Therapy (ECT) (e.g. Shock Therapy) *Facility Outpatient* *Note: ECT therapy during inpatient admission, refer to Mental Health Inpatient Facility section for benefit.*	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Electroconvulsive Therapy(ECT) (e.g. Shock Therapy) *Physician/Provider Outpatient* *Note: ECT therapy during inpatient admission, refer to Mental Health Inpatient Facility section for benefit.*	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Mental Health *Inpatient Facility*	Plan pays 75% after Deductible.	**Y**	Plan pays 60% after Deductible.	**Y**
Mental Health *Inpatient Physician/Provider*	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Mental Health *Outpatient*	Plan pays 75%	N	Plan pays 60% after Deductible.	N
Mental Health *Partial Hospitalization* *Care that is provided in lieu of inpatient mental health hospitalization at an approved facility*	Plan pays 75%	**Y**	Plan pays 60% after Deductible.	**Y**
Pharmacological (chemotherapy) Management *A brief interaction between a psychiatrist and a member for the primary purpose of reviewing medications and issuing a prescription with minimal psychotherapy*	Plan pays 75%	N	Plan pays 60% after Deductible.	N
Residential Treatment ***Intensive Residential Rehabilitation Services** are Residential Services requiring 24/7 treatment in a structured environment.* ***Note**: Community Residential Services and Supportive Living Services are **NOT** covered.*	Plan pays 75% after Deductible.	**Y**	Plan pays 60% after Deductible.	**Y**
MRI & MRA – SEE RADIOLOGY SERVICES (ADVANCED)				

PASSPORT SELECT				
Benefit Description	**IN-NETWORK (Participating)**	**Member Precertification Required**	**OUT-OF-NETWORK (Non-Participating)**	**Member Precertification Required**
NUTRITIONAL COUNSELING				
Nutritional Counseling	Plan pays 100%.	N	Plan pays 60% after Deductible.	N
NUTRITIONAL SUPPLIES				
Enteral & Parenteral Pumps	See DME Benefit	N	See DME Benefit	N
Parenteral Nutritional Supplies **Parenteral Nutrition** A feeding method in which nutrients go directly into the bloodstream through a catheter/IV placed into a vein, nutrition taken intravenously bypassed the digestive tract. You may also see terms TPN (total parenteral nutrition) or HA (hyperalimentation) used.	Plan pays 75% after Deductible. If provided in conjunction with Home Infusion Visit.	**Y**	Plan pays 60% after Deductible. If provided in conjunction with Home Infusion Visit.	**Y**
Enteral Formula & Supplies **Enteral Formula:** Administered via feeding tube* or as a liquid oral nutritional therapy when there is a documented diagnostic condition where caloric and dietary nutrients from food cannot be metabolized. Individuals must meet medically necessary criteria. Enteral formulas are ordered by practitioners and dispensed by pharmacy. May be administered as a Home Infusion service.	Plan pays 75% after Deductible. If provided in conjunction with Home Infusion Visit.	**Y**	Plan pays 60% after Deductible. If provided in conjunction with Home Infusion Visit.	**Y**
PKU Food Supplements	Covered under Pharmacy Benefit.	N	Not Covered	N
OFFICE VISITS				
Primary	Plan pays 100% after $25 Copayment	N	Plan pays 60% after Deductible.	N
Specialist	Plan pays 100% after $40 copayment	N	Plan pays 60% after Deductible.	N
ORTHOTICS				
Orthotics *Removable shoe inserts are NOT covered. For all other orthotics please refer to the P&A benefit*	Plan pays 80% after Deductible.	**Y**	Plan pays 50% after Deductible.	**Y**
OSTOMY SUPPLIES				
Ostomy Supplies	Plan pays 80% after Deductible.	**Y**	Plan pays 50% after Deductible.	**Y**

PASSPORT SELECT				
Benefit Description	**IN-NETWORK (Participating)**	**Member Precertification Required**	**OUT-OF-NETWORK (Non-Participating)**	**Member Precertification Required**
OUTPATIENT SURGICAL PROCEDURES				
Facility	Plan pays 75% after Deductible.	**Y**	Plan pays 60% after Deductible.	**Y**
Physician/Provider – Facility Based	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Physician/Provider – Office Based	Plan pays 75% after Deductible.	**Y**	Plan pays 60% after Deductible.	**Y**
Other outpatient services not listed (e.g. IV therapy, infusion, blood transfusions, etc.)	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
PAIN MANAGEMENT – SEE OUTPATIENT SURGICAL PROCEDURES				
PHYSICIAN/PROVIDER VISIT -INPATIENT				
Physician/Provider Visit -Inpatient	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
PODIATRY **Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).** **Routine foot care for covered persons with certain medical conditions affecting the lower limbs.**				
Facility – Outpatient	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Podiatrist – Facility Outpatient Based	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Podiatrist – Office Based Surgical Procedures	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Podiatrist – Office Visit (E&M)	Plan pays 100% after $40 Copayment	N	Plan pays 60% after Deductible.	N
PREVENTIVE SERVICES				
Includes, but not limited to, all services that have a rating of A or B from the United States Preventive Task Force and their corresponding limitations. Please refer to http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm for the full list and such other lists as specified by the Federal Government including the ACIP http://www.cdc.gov/vaccines/schedules/easy-to-read/index.html and HRSA http://www.hrsa.gov/affordablecareact/index.html and as may be amended from time to time				
PROSTHETICS AND APPLIANCES (P&A)				
Prosthetics and Appliances (P&A)	Plan pays 80% after Deductible.	**Y**	Plan pays 50% after Deductible.	**Y**

PASSPORT SELECT				
Benefit Description	**IN-NETWORK (Participating)**	**Member Precertification Required**	**OUT-OF-NETWORK (Non-Participating)**	**Member Precertification Required**
PULMONARY REHAB (LIMIT 24 VISITS PER PLAN YEAR. IN-NETWORK PLUS OUT-OF-NETWORK SERVICES COMBINED EQUALS THE TOTAL BENEFIT)				
Pulmonary Rehab	Plan pays 75% after Deductible.	**Y**	Plan pays 60% after Deductible.	**Y**
RADIATION THERAPY				
Professional Services	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Technical Services	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
RADIOLOGY (X-RAYS)				
Routine X-rays Technical Services	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Routine X-rays Professional Services	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Advanced Radiology Technical Services *Advanced Radiology Services includes:MRI, MRA, CT Scan, PET Scan and Myocardial Nuclear Perfusion Imaging.*	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Advanced Radiology Professional Services	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
REVERSAL OF ELECTIVE STERILIZATION – NOT COVERED				
ROUTINE PHYSICALS				
Routine Physicals (19 years & older)	Plan pays 100%.	N	Not Covered	N
SCOPES				
Facility – Outpatient	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Physician – Facility Outpatient Based	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Physician – Office Based Scope Procedures	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N

PASSPORT SELECT				
Benefit Description	**IN-NETWORK (Participating)**	**Member Precertification Required**	**OUT-OF-NETWORK (Non-Participating)**	**Member Precertification Required**
SKILLED NURSING FACILITY (SUB-ACUTE)				
Facility (Limit of 45 days per plan year)	Plan pays 75% after Deductible.	**Y**	Plan pays 60% after Deductible.	**Y**
Physician/ Ancillary Visits	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
SLEEP STUDIES				
Sleep Studies	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
SMOKING CESSATION				
Smoking Cessation Counseling and Intervention	Plan pays 100%.	N	Plan pays 60% after Deductible.	N
TERMINATION OF PREGNANCY				
Facility	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Physician/Provider – Facility Based	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Physician/Provider – Office Based	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
THERAPIES – OUTPATIENT (LIMIT 20 VISITS PER PLAN YEAR. IN-NETWORK PLUS OUT-OF-NETWORK SERVICES COMBINED EQUALS THE TOTAL BENEFIT)				
Physical Therapy	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Occupational Therapy	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Speech Therapy	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
TRANSPLANTS				
Donor (donates the organ)	Claims need to be submitted to the donor's insurance company. An EOB from the other insurance then needs to be submitted to IH. IH will reimburse for the donation charges under the recipient's IH ID # if the other insurance	**Y**	Plan pays 60% Coinsurance after Deductible. Claims need to be submitted to the donor's insurance company. An EOB from the other insurance then needs	**Y**

PASSPORT SELECT				
Benefit Description	**IN-NETWORK (Participating)**	**Member Precertification Required**	**OUT-OF-NETWORK (Non-Participating)**	**Member Precertification Required**
	carrier denies the claim or if there is a balance remaining once the other insurance has paid, IH will coordinate benefits. Costs and/or services related to searches and/or screenings for donors of organs to be transplanted are not covered. Member liability based on services rendered.		to be submitted to IH. IH will reimburse for the donation charges under the recipient's IH ID # if the other insurance carrier denies the claim or if there is a balance remaining once the other insurance has paid. IH will coordinate benefits. Costs and/or services related to searches and/or screenings for donors of organs to be transplanted are not covered.	
Recipient (receives the organ)	Recipient must be a covered person of IH. Member liability based on services rendered.	**Y**	Plan pays 60% after Deductible. Recipient must be a covered person of IH.	**Y**
TUBAL LIGATION				
Facility	Plan pays 100%.	N	Plan pays 60% after Deductible.	N
Physician – Facility Based	Plan pays 100%.	N	Plan pays 60% after Deductible.	N
URGENT CARE **IF COVERED PERSON RECEIVES URGENT CARE IN THE EMERGENCY ROOM, THE ER COPAY APPLIES.**				
In-Area (Providers Office)	Plan pays 100% after Office Visit Copy.	N	Plan pays 60% after Deductible.	N
Participating Urgent Care Center	Plan pays 100% after $40 Copayment.	N	N/A	N
Out-of- Area	If the member calls 24-Hour Medical Help Line prior to services being rendered, the member is responsible for in-network copayments. The copayment applies per provider per date of service, whether or not the service would normally take a copayment in-network. (e.g. lab work takes an office visit copayment under this benefit).	**Y**	Plan pays 60% after Deductible if member fails to precertify. Covered as In-Network if member does precertify.	**Y**
VASECTOMY				
Facility	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Physician – Facility Based	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N
Physician – Office Based	Plan pays 75% after Deductible.	N	Plan pays 60% after Deductible.	N

PASSPORT SELECT				
Benefit Description	**IN-NETWORK (Participating)**	**Member Precertification Required**	**OUT-OF-NETWORK (Non-Participating)**	**Member Precertification Required**
WELL BABY/CHILD CARE				
Well Baby/Child Care *(0-18 years)* AAP-American Academy of Pediatrics	Plan pays 100% up to age 19 according to AAP guidelines.	N	Plan pays 60% after Deductible.	N

MEDICAL PLAN COVERED SERVICES

Covered Services are determined either by the rates agreed upon with a Participating Provider or the Usual, Customary and Reasonable Charges with respect to covered services rendered by a Non-Participating Provider that are incurred for the following items of service and supply. **These Covered Services are subject to the limitations (as set forth in the Schedule of Benefits), Exclusions and other provisions of this SPD.** A charge is incurred on the date that the service or supply is performed or furnished. In addition to the provisions set forth below, the Plan utilizes certain Independent Health policies and procedures with respect to Covered Services under the Plan.

1. **Alcohol and Substance Abuse.**

2. **Allergy** (testing, injections, and serum).

3. **Ambulance.** Use of Ambulance services (land or air) may be reviewed retrospectively for Medical Necessity.

4. **Anesthesia.**

5. **Assistant Surgeon.**

6. **Autologous Blood.**

7. **Blood and Plasma.**

8. **Cardiac Rehabilitation.**

9. **Chemotherapy and Radiation**. The materials and services of technicians are included.

10. **Chiropractic Care.**

11. **Clinical Trials.** The Plan will cover "Routine Patient Costs" for a "Qualified Individual" participating in an "Approved Clinical Trial." For purposes of this coverage, the following definitions apply:

    a. **Routine Patient Costs** means all items and services consistent with Plan coverage that is typically covered for a Participant who is not enrolled in a Clinical Trial.

    b. **Qualified Individual** means a Participant who is eligible to participate in an Approved Clinical Trial according to trial protocol with respect to treatment of cancer or other Life-Threatening Condition and either the (i) Participant's Physician has concluded that participation is appropriate, or (ii) Participant provides medical and scientific information establishing that their participation is appropriate.

    c. **Approved Clinical Trial** means a Phase I, II, III or IV Clinical Trial for the prevention, detection or treatment of cancer or other Life-Threatening Condition or disease (or other condition described in the Affordable Care Act) such as federally funded trials (identified in the Affordable Care Act), trials conducted under an Investigational new drug application reviewed by the FDA or drug trials exempt from having an investigational new drug application.

    d. **Life-Threatening Condition** means any disease from which the likelihood of death is probable unless the course of the disease is interrupted.

12. **Contraceptives.**

13. **Dental.** Medically Necessary Dental care and treatment due to accidental Injury to sound natural teeth occurring within 12 months from the date of the accidental Injury, and Dental care and treatment Medically Necessary due to congenital disease or anomaly.

14. **Diabetic Equipment and Supplies.**

15. **Diabetic Teaching.** (covered under Preventive Services).

16. **Diagnostic Testing.**

17. **Dialysis.**

18. **Durable Medical Equipment.** Rental of Durable Medical Equipment or surgical equipment if deemed

Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Claims Administrator.

19. **Electroconvulsive Therapy.**

20. **Emergency Care** (facility and Physician/Provider).

21. **Experimental and/or Investigational.** Experimental and/or Investigational treatments, procedures, drugs and devices are generally not a Covered Service. See Plan Exclusion for exceptions.

22. **Family Counseling.**

23. **Hearing.** Medically Necessary hearing tests ordered by a Physician/Provider.

24. **Hearing Aids.** Only Cochlear Implant and Bone Anchored Hearing Aid (BAHA) are covered. Must be FDA approved.

25. **Home Health Care.** When ordered by a Physician/Provider in accordance with a treatment plan approved in writing by the Medical Director as an alternative to (or to prevent) hospitalization or treatment in a Skilled Nursing Facility. Services eligible for coverage include: a) part-time or intermittent home nursing care by or under the supervision of a registered professional nurse; b) part-time or intermittent home health aide which consists primarily of caring for the Plan Participant; c) physical, Medical Supplies or Speech Therapy which consists primarily of caring for the Plan Participant; d) Medical Supplies that are rendered in the home; e) drugs and medications, including Home Infusion Therapy prescribed by a Physician/Provider; and f) Laboratory Services by or on behalf of the Home Health Agency, to the extent such items would have been covered or provided if the Plan Participant were hospitalized or confined in a Skilled Nursing Facility.

26. **Home Infusion Therapy.**

27. **Home Visits.**

28. **Hospice.** Coverage for Advanced Care Planning, inpatient care, outpatient care, home care, and bereavement counseling.

29. **Hospital** (facility and Physician/Provider).

30. **Immunizations.**

31. **Infertility.** Evaluation, testing and diagnostic services as set forth below (see Plan Exclusions for specific services not covered). The Infertility benefit does not cover treatment for the partner, if the partner is not a Plan Participant under the Plan.

32. **Injections.**

33. **Laboratory and Pathology.**

34. **Mammograms.**

35. **Mastectomy.** This Plan covers: a) all stages of reconstruction of the breast on which the Mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; b) Prostheses; and c) treatment for physical complications at all stages of Mastectomy, including lymphedemas, in the manner determined in consultation with the attending Physician/Provider and the Plan Participant.

36. **Maternity Care.** Obstetrical services. A Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician/Provider and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

    Group health plans generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Physician/Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case,

plans may not, under federal law, require that a Physician/Provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Home births are a Covered Service under the Plan when performed by a Physician/Provider who meets credentialing standards established by Nova Healthcare.

37. **Medical Services and Supplies.**

38. **Mental Health.**

39. **MRI / MRA / CAT / Nuclear.**

40. **Nutritional Counseling** (covered under Preventive Services).

41. **Occupational Therapy.**

42. **Office Visits.**

43. **Orthotics.** See Plan Exclusions for specific services not covered

44. **Ostomy Supplies.** See Prosthetics and Appliances.

45. **Outpatient Surgical Procedures.**

46. **Pap Smear.**

47. **Physical Therapy.**

48. **Physician/Provider Visit.** Coverage is available for Physician/Provider's services when a Plan Participant is in the Hospital, Skilled Nursing Facility, outpatient facility, in Physician's office or Participant's home.

49. **Podiatry.** See Plan Exclusions for specific services not covered.

50. **Preadmission Testing.**

51. **Preventive Services.** The services will include all services designated as Preventive by the United States Preventive Services Task Force and their corresponding limitations.

52. **Prostate Screening.**

53. **Prosthetics and Appliances (P&A).** Includes: a) the purchase, fitting and repair of fitted Prosthetic devices and Medical appliances which replace body parts, including Ostomy supplies; and b) replacement, repair and maintenance are covered when functionally necessary if it is not covered under manufacturer's warranty or purchase agreement and not the result of misuse. Medically Necessary orthopedic devices dispensed at a Physician/Provider's office will be covered under the Physician Visit benefit

54. **Pulmonary Rehabilitation.**

55. **Radiation Therapy.**

56. **Radiology** (X-Rays).

57. **Routine Physicals.**

58. **Second Surgical Opinions.**

59. **Skilled Nursing Facility.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when: a) the Plan Participant is confined as a bed patient in a facility; b) the attending Physician/Provider certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and c) the attending Physician/Provider completes a treatment plan which includes a Diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

60. **Sleep Studies.** Medically Necessary for the Diagnosis and treatment of sleep disorders.

61. **Speech Therapy**. Therapy must be ordered by a Physician/Provider and follow either: a) Surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy)

of a person; b) an Illness or Injury; or c) an Illness that is other than a learning or Mental Health Condition.

62. **Sterilization.**

63. **Temporomandibular Joint (TMJ) Treatment.** Will only be covered if the TMJ is the direct cause ofanother medical condition.

64. **Termination of Pregnancy.** Only covered when the women's life would be in danger if the fetus was carried to term or when the pregnancy is the result of rape or incest.

65. **Tobacco Cessation.** Charges incurred for tobacco cessation classes and products are covered as described in the Schedule of Benefits.

66. **Transplants.** Benefits for service rendered in a Center of Excellence will be based on the service rendered (Example: surgeon's charges under the physician benefit). Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

    a. Costs and/or services related to searches and/or screenings for donors of organs to be transplanted are not covered.

    b. No transportation, companion food or lodging charges will be considered.

    c. Claims need to be submitted to the donor's insurance carrier. An EOB from the other insurance carrier then needs to be submitted to Nova Healthcare. Nova Healthcare will reimburse for the donation charges under the recipient's ID number if the other insurance carrier denies the claim or if there is a balance remaining once the other carrier has paid. Nova Healthcare will coordinate benefits.

    The Plan will always pay secondary to any other coverage. Donor coverage for transplants provided only if not covered under donor's plan. Donor charges in those cases will be coordinated with any primary plan and covered under the recipient's identification number.

    Organ recipients must be a Covered Person under the Plan.

    Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:

    a. evaluating the organ or tissue;

    b. removing the organ or tissue from the donor; and transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

67. **Urgent Care.**

68. **Vasectomy.**

69. **Vision.** Medically Necessary eye examinations for the treatment of Illness or Injury.

70. **Well Child Care.**

71. **Women's Wellness.**

MEDICAL PLAN EXCLUSIONS

For all Medical benefits shown in the Schedule of Benefits, a charge for the following is not covered:

1. **Acupuncture.**

2. **Applied Behavioral Analysis, treatment or communication devices.**

3. **Clinical Trials**. Clinical Trial that do not meet the definition of an Approved Clinical Trial (see Medical Benefits). In additional, the following shall be excluded when provided in the context of a Clinical Trial:

    a. The investigational item, devise or service itself;
    b. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
    c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

4. **Complications of Non-Covered Services**. Care, services or treatment required as a result of complications from a treatment not covered under the Plan.

5. **Convenience Items**. Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

6. **Cosmetic**. Any health care service rendered for Cosmetic purposes including any procedures which are not Medically Necessary services, or any services or items connected with a Cosmetic operation. A Cosmetic health care service is covered only when it is Medically Necessary, for example: reconstructive Surgery when incidental to or when it follows Surgery resulting from trauma, infection or other diseases of the involved part, including but not limited to, breast reconstruction Surgery after a Mastectomy and reconstructive Surgery because of congenital disease or anomaly of a covered family Dependent child which results in a functional impairment. Examples of Cosmetic services and items that are not covered unless Medically Necessary include, but are not limited to: a) rhinoplasty; b) reconstructive Surgery for scar repair or revision where no physiological functional defect is present; c) cranial Prosthesis, wigs and hair replacements; d) Cosmetic devices; e) sex change procedures; and f) drugs and biologicals used for Cosmetic purposes, even if the drug or biological is otherwise covered.

7. **Custodial Care**.

8. **Dental**. Any regular Dental care and treatment including, but not limited to: a) orthodontia; b) prosthodontics;c) periodontics; d) dentures; e) devices and appliances used in conjunction with the teeth; f) procedures involving teeth or areas surrounding teeth; g) orthognathic Surgery, including shortening of the mandible or maxillae for correction of malocclusion; and h) all professional, Hospital and Anesthesia services, except for Medically Necessary Dental care and treatment due to accidental Injury to sound natural teeth occurring within 12 months from the date of the accidental Injury, and Dental care and treatment Medically Necessary due to congenital disease or anomaly. Care for TMJ can be either Medical or Dental in nature. Coverage for TMJ is excluded when it is Dental in nature.

9. **Diabetic Shoes and custom molded shoe Inserts.**

10. **Durable Medical Equipment.** Computer assisted communication devices or electronic communication devices, items such as air conditioners, humidifiers, and athletic equipment.

11. **Educational or Vocational Testing**. Services for educational or vocational testing or training, unless otherwise specified.

12. **Excess Charges.** The part of an expense for care and treatment of an Illness or Injury that is in excess of the Usual, Customary and Reasonable Charge.

13. **Exercise Programs.** Exercise programs for treatment of any condition, except for Physician/Provider-supervised Cardiac Rehabilitation, Medical Supplies or Physical Therapy covered by

this Plan.

14. **Experimental and/or Investigational.** Experimental and/or Investigational treatments, procedures, drugs and devices. As an exception, Investigational or Experimental procedures which are proven to be safe and efficacious, based on reliable evidence for a particular Illness or Injury, may be covered. The Plan Administrator and/or Claims Administrator reserves the right to determine Coverage on a case-by-case basis, based upon Medical documentation and reliable evidence.

    Additionally, with respect to Clinical Trials, the Plan will cover "Routine Patient Costs" for a "Qualified Individual" participating in an "Approved Clinical Trial" (see MEDICAL BENEFITS), as well as any side effects and/or complications associated with the Approved Clinical Trial.

15. **Eye Care.** Radial keratotomy or other eye surgery to correct refractive disorders. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

16. **Foreign Travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining Medical services.

17. **Genetic Testing**.

18. **Government Coverage**. Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

19. **Hair Loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, that are for male pattern baldness, female pattern baldness or natural aging whether or not prescribed by a Physician/Provider.

20. **Hearing Aids and Evaluations**. Charges for services or supplies in connection with hearing aids or evaluations for their fitting.

21. **Hospital Employees**. Professional services billed by a Physician/Provider or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

22. **Illegal Acts.** Charges for services received as a result of Illness or Injury occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this Exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this Exclusion to apply. Proof beyond a reasonable doubt is not required. This Exclusion does not apply if the Illness or Injury resulted from an act of domestic violence or a Medical (including both physical and Mental Health) Condition.

23. **Illegal Drugs or Medications.** Services, supplies, care or treatment to a Plan Participant for Illness or Injury resulting from that Plan Participant's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a Physician/Provider. Expenses will be covered for injured Plan Participants other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This Exclusion does not apply if the Injury resulted from an act of domestic violence or a Medical (including both physical and Mental Health) Condition.

24. **Infertility.** Infertility treatment except as described under Medical Plan Covered Services.

25. **Maintenance Therapy.** Services primarily to maintain a level of physical or mental function.

26. **Marital or Pre-marital Counseling.** Care and treatment for marital or pre-marital counseling.

27. **Medical Record Expenses.** The costs associated with the reproduction and furnishing of X-Rays and Medical records.

28. **No Charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

29. **Non-compliance.** All charges in connection with treatments or medications where the Plan Participant either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against Medical advice. Any expense as a result of your failure to vacate any Hospital or Skilled Nursing Facility bed beyond the discharge date established by the facility, Participating Provider, your Physician/Provider, and us.

30. **No-Fault.** Charges required to be paid in connection with No-Fault insurance.

31. **No Obligation to Pay.** Charges incurred for which the Plan has no legal obligation to pay.

32. **No Physician/Provider Recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician/Provider; or treatment, services or supplies when the Plan Participant is not under the regular care of a Physician/Provider. Regular care means ongoing Medical supervision or treatment which is appropriate care for the Illness or Injury.

33. **Occupational/Workers' Compensation.** Care and treatment of an Illness or Injury that is occupational (arises from work for wage or profit including self-employment).

34. **Organ Transplant Expenses.** Costs and/or services related to searches and/or screenings for donors of organs to be transplanted.

35. **Physical Therapy**. Recreational programs, maintenance therapy or supplies used in Physical Therapy.

36. **PKU Food Supplements.**

37. **Plan Design Excludes**. Charges excluded by the Plan design as mentioned in this document.

38. **Podiatry.** Routine and palliative foot care: including but not limited to services or care in connection with any of the following: corns; calluses; flat feet; fallen arches; weak feet; chronic foot strain; symptomatic complaints of the feet, or orthotics.

39. **Private Duty Nursing.** Charges in connection with care, treatment or services of a private duty nurse.

40. **Recreational Programs**.

41. **Relative Giving Services.** Professional services performed by a person who ordinarily resides in the Plan Participant's home or is related to the Plan Participant as a Spouse, parent, child, brother or sister.

42. **Respite Care.**

43. **Reversal of Elective Sterilization.**

44. **Self-administered Injectables.** Except as specifically provided in this Plan or the third party administrators formulary.

45. **Services Before or After Coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

46. **Services and Items that are Not Medically Necessary**. Health care services and items that are not Medically Necessary for the Diagnosis and treatment of an accidental Illness or Injury, or to maintain your health are excluded. This Plan covers only Medically Necessary services unless otherwise specified.

47. **Services and Items that are Not Safe and/or Efficacious.** Medical, surgical or other treatments, procedures, techniques, and drug or pharmacological therapies not proved to be safe and/or efficacious, or, because of your condition, an efficacious procedure that will have no effect on the outcome of your Illness or Injury are not covered. Benefits are limited to scientifically established procedures that have been evaluated by recognized authorities or governmental agencies and have been found to have a demonstrable curative or significantly ameliorative effect for a particular Illness or Injury. Procedures that are ineffective or in the state of being tested or researched with question(s) as to safety and/or efficacy are not covered. Experimental and/or Investigational procedures, which are proven to be safe and efficacious for a particular Illness or Injury, may be covered. See Experimental and/or Investigational under Plan Exclusions for procedures which may be covered.

48. **Services and Items Not Specified as Covered**. This Plan will not provide coverage for any service or item that is not specifically described by this Plan as covered, even when: a) a Physician/Provider prescribes the service or item, or otherwise considers it to be Medically Necessary and appropriate; or b)

the service or item is not specifically identified by this Plan as excluded.

49. **Services and Items Required by Third Parties.** Physical and mental examinations and Immunizations, and drug testing required by Third Parties for obtaining or maintaining employment or insurance, Medical research, travel, school, or camp, court ordered examinations, and hospitalizations except when Medically Necessary.

50. **Services for Which Payment has Been Made.** Any fees for the services of a health care Physician/Provider employed by a Hospital or institution to which a global or case-based payment is made.

51. **Sex Changes.** Care, services or treatment for non-congenital transsexuals, gender dysphasia or sexual reassignment or change. This Exclusion includes medications, implants, hormone therapy, Surgery, Medical or psychiatric treatment.

52. **Storage of Blood or Blood Products.** This does not apply to Autologous Blood (one's own) donations. Benefits for transfusion services, including storage, for Autologous donations of Blood and Blood Products are available when associated with a scheduled, covered surgical procedure.

53. **Television or Phone Charges.**

54. **Transplants.** Costs and/or services related to searches and/or screenings for donors of organs to be transplanted are not covered and no transportation, companion food or lodging charges will be considered.

55. **Travel or Accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician/Provider, except for Ambulance charges as defined as a Covered Service.

56. **War.** Any loss that is due to a declared or undeclared act of war.

57. **Weight Loss Programs and/or Dietary Control Programs or Other Programs with Dietary Supplements.**

58. **Wheelchair Van Transportation.**

PASSPORT SELECT
PRESCRIPTION DRUG SCHEDULE OF BENEFITS

Retail Pharmacy Option – 30 day supply

Tier 1: Preferred Generic and Select OTCs Copay	Plan Participant pays $10.00
Tier 2: Preferred Branded Drugs Copay	Plan Participant pays $30.00
Tier 3: Non-Preferred Drugs Copay	Plan Participant pays $50.00
Tier 4: Non-Preferred Drugs Copay	Plan Participant pays $500.00

Mail Order Prescription Drug - 90-Day Supply Option

Tier 1: Preferred Generic and Select OTCs Copay	Plan Participant pays $25.00
Tier 2: Preferred Branded Drugs Copay	Plan Participant pays $75.00
Tier 3: Non-Preferred Drugs Copay	Plan Participant pays $125.00

Pharmacy Out of Pocket Maximum

Individual	$1,600.00
Family	$3,200.00

PRESCRIPTION DRUG COVERED SERVICES

1. **Acne Products**.
2. **ADD Drugs**.
3. **Anabolic Steroids**. Requires prior authorization for medical necessity. Not covered for the purpose of body building.
4. **Compounded Products**. Prescriptions containing at least one prescription ingredient in a therapeutic quantity.
5. **Contraceptives. Devices, injectables, oral medication and patches**. Refer to Medical Plan benefits for Contraceptives administered in the Physician/Provider's office.
6. **Cox-2 Inhibitors**.
7. **Dental Specific Products**. Includes, but not limited to, gels, pastes, rinses, etc.
8. **Diabetic Needs**
9. **Diabetic (oral)**
10. **Disposable Medical Supplies**. Includes, but not limited to, spacers, peak flow meters, etc.
11. **Diabetic Equipment and Supplies** (can be supplied by a Pharmacy or Medical vendor, copayment is based on the servicing provider)
12. **Insulin**
13. **Experimental and/or Investigational**. Generally not a Covered Service. See Pharmacy Exclusions for exceptions.
14. **Impotence Agents**.
15. **Infertility**.
16. **Mail Order**. Available for maintenance medications.
17. **Migraine Agents**.
18. **Nutritional Formulas**. Enteral formulas, food supplements, and PKU supplements.
19. **Prescription Vitamins**.
20. **Proton Pump Inhibitors**.
21. **Specialty Drugs**. Must be obtained through a Specialty Pharmacy.
22.
23. **Substance Abuse / Addiction Medication**.
24. **Tablet Splitting**.
25. **Smoking Cessation**.
26. **Vaccines Administered at a Pharmacy**.

PRESCRIPTION DRUG EXCLUSIONS

Drugs purchased from a Non-Participating Pharmacy are not covered, except for drugs required for urgent and emergent services as determined by the Claims Administrator.

This benefit will not cover a charge for any of the following

1. **Administration.** Any charge for the administration of a covered Prescription Drug.

2. **Anorexiants/Antiobesity Agents.** Agents used to suppress appetite and control fat absorption.

3. **Cosmetic.**

4. **Experimental and/or Investigational.** Drug or pharmacological therapies not proved to be safe and/or efficacious, or, because of the Plan Participant's condition, an efficacious procedure that will have no effect on the outcome of the Plan Participant's Illness or Injury are not covered**.** An Investigational drug is a drug or medicine labeled: "Caution - limited by federal law to Investigational use." **Investigational or Experimental procedures which are proven to be safe and efficacious for a particular Illness or Injury which have received approval from the FDA and/or the National Institute of Health Technology Assessment are covered.** The Medical Director reserves the right to determine coverage on a case-by-case basis.

5. **Inpatient Medication.** While confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

6. **No Charge.** A charge for Prescription Drugs which may be properly received without charge.

7. **No Prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

8. **Non-Participating Pharmacy**. Except for drugs required for urgent and emergent services as determined by the Claims Administrator.

9. **Over the Counter (OTC) Drugs**. Select OTC drugs are covered with a written prescription based on the Plan Formulary.

10. **Services and Items Not Specified as Covered**. This Plan will not provide coverage for any service or item that is not specifically described by this Plan as covered, even when: a) a Physician/Provider prescribes the service or item, or otherwise considers it to be Medically Necessary and appropriate; or b) the service or item is not specifically identified by this Plan as excluded.

11. **Services Before or After Coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

PASSPORT SELECT VISION CARE
SCHEDULE OF BENEFITS

Benefits for these charges are payable up to the maximum benefit amounts shown below for each Vision care service or supply. Frame, lenses and lens options must bepurchased in same transaction to receive full discount. Benefits are available through participating providers only.

Routine Exam (once every 12 months)	Plan participant pays $20 per visit
Frames	Plan participant pays 60% of retail price
Standard Plastic Lenses	
Single vision	Plan participant pays $50
Bifocal	Plan participant pays $70
Standard progressive	Plan participant pays $105
Contact Lenses (discount applies to materials only)	Plan participant pays 85% of retail price
Laser Vision Correction	Plan participant pays 85% of retail price

VISION CARE EXCLUSIONS

The following is a list of certain Exclusions under the Plan:

1. **Health Plan.** Any charges that are covered under any other health plan that reimburses a greater amount than this Plan.
2. **Medical Eye Examination**.
3. **No Prescription.** Charges for any Vision benefits not accompanied by a prescription.
4. **Orthoptics.** Charges for orthoptics (eye muscle exercises).
5. **Services Before or After Coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
6. **Services and Items Not Specified as Covered**. This Plan will not provide coverage for any service or item that is not specifically described by this Plan as covered, even when: a) a Physician/Provider prescribes the service or item, or otherwise considers it to be Medically Necessary and appropriate; or b) the service or item is not specifically identified by this Plan as excluded.
7. **Training.** Charges for Vision training or subnormal Vision aids.
8. **Any eye or Vision examination, or any corrective eyewear required as a condition of employment.**
9. **Safety eyewear**.
10. **Fitting for follow up visits contact lenses.**
11. **Disposable contact lenses**.